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ABSTRACT

Presented is the Illinois Regional Resource Center's Manual for Diagnostic Teachers which is designed to provide a model for assessment, individualized educational planning, optimal placement, and short and long range follow-up of children (3-21 years old) with unexplained learning problems. Section 1 provides an introduction to the Illinois-Regional Resource Center Diagnostic Teaching Model (IRDTM) with sections on the model's purpose, target population, and 11 features of the IRTDM (such as the emphasis on diagnosis rather than remediation; the delivery of both on-site and in-classroom services; and a holistic approach which covers the motor, sensory-perceptual, academic, speech/language, social-emotional, and self-help domains). Section 2 makes up the bulk of the document with flow charts on the five phases of the model--initial information gathering, on-site or in-classroom diagnosis, program development and testing, transition, and follow-up. Among the exhibits presented in section 3 are samples of a referral form; follow-up form; case contact record; formal and informal test score worksheets; teacher, parent, and child follow-up records; informal and formal evaluation data summaries, and federal reporting form. A hypothetical case study for the IRDTM is given in section 4 which provides examples of the written materials produced by the diagnostic team during the diagnostic, program development, and testing phases. Among appended materials in a final section are regional resource center job descriptions; suggested qualifications for diagnostic teachers; a list of consultants available to the regional resource center team; and bibliographies of diagnostic tests, instructional materials and equipment, and behavioral checklists. (SBH)

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The Illinois Regional Resource Center

MANUAL FOR DIAGNOSTIC TEACHERS

Prepared in cooperation with the

Regional Resource Center #7

School District 150, Peoria, Illinois

by

Validated Instruction Associates, Inc.

with

technical assistance from

Illinois State University

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August, 1976

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PREFACE TO DIAGNOSTIC TEACHERS

In recent years, state and federal legislation has reflected the increasing public concern for providing handicapped children with high-quality, comprehensive services. Local agencies and institutions, too, have addressed the problems of exceptional children, often developing cooperative efforts at the district and regional levels to provide classroom support services and to serve comprehensively children with unusual educational needs.

While these programs have proved highly successful in helping many children, they also have drawn the focus of attention to a group of children whose needs heretofore have been met inadequately. These are children with rare or unexplained learning disabilities--children for whom learning diagnosis and prescription at local and regional facilities, if available at all, has proved ineffective and who thus continue to display a bewildering and frustrating variety of physical, psychological, behavioral, emotional, and educational handicaps.

THE ILLINOIS REGIONAL RESOURCE CENTER'S DIAGNOSTIC TEACHING MODEL AND ITS REPLICATION

To assist such children, the Bureau of Education for the Handicapped established and funded 13 Regional Resource Centers, of which RRC #7 in Peoria is one.

The mandate of RRC #7 provides for establishing and field testing a prototypical diagnostic and prescriptive program for children with rare and unexplained learning problems and for installing that program throughout the State of Illinois in a replication effort.

This replication effort is now in complete operation.

From each of your districts the regional directors or their representatives already have been involved in the process. They have attended a series of workshops which have acquainted them in general with the procedures you will learn here in detail, and have been provided the information necessary to enlist the support of their regional boards and other constituencies.

You were chosen to represent your region at this workshop because of your level of professional expertise and your commitment to special education.

WORKSHOP OBJECTIVES

Upon completion of this workshop, participants, in concert with other members of a diagnostic team, will be able to:

1) systematically gather and record all relevant data collected from sending teacher interviews, parent and child interviews, as well as other data sources, with implications for an accurate and comprehensive diagnosis of a child with unexplained learning disabilities.

2) systematically formulate specific written diagnostic team objectives and an individual behavioral change plan based on data gathered during Phase I of the IRDTM; further, to conceptualize a comprehensive diagnostic summary based on the systematic use of formal and informal tests, classroom observation, and medical and other relevant consultants.

3) systematically conceptualize and articulate for a given child with learning disabilities a written individualized educational plan which results from the formulation of long and short range program objectives, a written task analysis, and initial and finalized program prescriptions which consist of existing or teacher - made instructional materials and strategies, a schedule of reinforcement strategies, a detailed description of optimal learning environments and teaching strategies, and a time-referenced individualized behavioral ladder.

4) systematically assess a given child's readiness for re-entry into his or her receiving system as well as prepare the receiving teacher by adapting the child's individual educational plan to the constraints of the receiving system and by training the receiving teacher and other implementers of the child's individual educational plan.

5) systematically providing follow-up services to assure the success of the child's individual education plan, and systematically collect follow-up data to self-correct and validate the Illinois Regional Resource Center Diagnostic Teaching Model.

PHILOSOPHY AND LAW

The replication process that we undertake here is deeply rooted both in American educational philosophy and in the law that has been devised to turn that philosophy into action.

The federal and state governments recognize in principle their obligation to provide every American child free appropriate public education. In making this right available and in providing access to that education, government at the state and the federal levels has recognized that many local school systems are fiscally unable to provide for the needs of extraordinary children. Accordingly, government has provided mechanisms for paying the excess cost for the special education of such children over and above the costs associated with the education of children in regular programs.

In November of 1975, the President signed the Education for all Handicapped Children Act (Public Law 94-142), which expanded the existing Education of the Handicapped Act and added some new dimensions.

Under the new law, the State Education Agency (SEA) must assure a free appropriate public education and assume responsibility for supervision of all handicapped children.

The law also provides for extensive child indentification, due process, confidentiallity and placement in the least restrictive environment. An individual educational plan for each handicapped child is also a provision of PL 94 - 142.

For those of you with special interest, copies of these laws or of excerpts from them can be made available upon request for examination.

BEST WISHES

Much rests upon your commitment to the task. The members of the workshop staff will do everything in their power to assist you in mastering and applying this system in your regions. Nor will the help stop when you leave here. Field assistance will be available when you return to your situations in the fall. Best wishes for a rewarding workshop and a successful year's teaching.

James W. Cook, Ph.D.
Chairman, Board of Directors
VALIDATED INSTRUCTION ASSOCIATES, INC.

J. Zink, Ph.D.
President
VALIDATED INSTRUCTION ASSOCIATES, INC.

WORKSHOP STAFF

HAROLD BERJOHN

Dr. Harold Berjohn is director of Regional Programs for Peoria District 150. These programs include the Mid Central Association, Title VI and Title I programs and the Regional Resource Center. Prior to this position, Dr. Berjohn worked for two years as director of Title III ESEA Project PRIDE in Georgia. This project used a differentiated staffing pattern to provide on-the-job training and support to regular classroom teachers. The training and support was designed to enable target teachers to serve moderately and mildly exceptional children in the regular classroom.

Dr. Berjohn received his B.A. from Loyola University of Chicago, his M.A. from Catholic University and his Ph.D. from Illinois State University. He has served as administrative assistant to the I.O.E., Title III Consultant and Research Assistant on the School District Survey report to the Illinois legislature. Dr. Berjohn has also served on the faculty of Illinois State University.

Dr. Berjohn has several years teaching experience in high school English. He also has taught elementary and high school special education classes. His publications include the Project PRIDE Planning and Training Manual and many video tape packages.

Dr. Berjohn was awarded ADMINSTRATOR OF THE YEAR for a seven county area in Georgia.

DEA BOKER

Ms Boker joined the Regional Resource Center for Illinois as Assistant Director in February, 1976. She was previously employed by Tazewell - Mason Counties joint agreement as a program coordinator. She served in this capacity for five years at which time she also supervised student teachers for Illinois State University.

Prior to living in the Central Illinois area, Ms Boker was employed as a teacher for high school mentally handicapped in Skokie, Illinois where she began the class at Niles East High School. She also taught special education, elementary and high school in Littleton, Colorado for several years.

Ms Boker received her B.A. in psychology from the University of Nebraska and her M.A. from the University of Denver. She is currently enrolled in the doctoral program at Illinois State University.

JAMES W. COOK

Chairperson of the Board of Directors of Validated Instruction Associates, Inc., Dr. Cook has in recent years acted as Principal Investigator for the U.S. Navy Leadership and Management Education and Training Project, the U.S. Navy Human Resources Management Instructor Training Task Analysis, the Michigan Department of Social Services Competency-Based Supervisory Training Project, and the Formative Evaluation System for the U.S. Navy Human Goals Program.

In addition, Dr. Cook has since 1964 been involved in faculty development efforts including the Great Lakes Colleges Association's Programmed Instruction Project and the Kellogg Foundation-Association of Independent Colleges and Universities of Michigan's faculty development project. Among the many companies and agencies whose training departments have sought Dr. Cook's counsel are Xerox Corporation, Western Electric, the Michigan Department of Social Services, Steelcase Inc., the U.S. Army Command and General Staff College, and the Chief of Naval Education and Training.

Among his publications Dr. Cook numbers Poetry: Method and Meaning, several articles on Chaucer, several on applications of instructional technology to the humanities, numerous video scripts, and several monographs.

He has also acted as a curriculum consultant for St. Anselm's College, for the American University in Cairo, Egypt, and for Walden University.

LANNY E. MORREAU

Dr. Morreau, Assistant Professor of Special Education at Illinois State University, has extensive experience in planning for handicapped persons. For six years, he taught educable mentally retarded children at the elementary and secondary levels, and his most recent experience involved the coordination and design of a deinstitutionalization plan for the State of Minnesota.

While serving as program coordinator for the Upper Midwest Regional Educational Laboratory, Dr. Morreau created a classroom model which responds to individual learner needs--a model which has subsequently been described in Behavioral Management in the Classroom. In addition he has designed and produced a programmed television sequence for instructing parents in techniques for modifying children's behavior using positive reinforcement procedures.

Dr. Morreau has authored several texts as well as nearly forty articles in the areas of instructional design and motivation. He has also served as consultant to numerous programs for handicapped persons, medical organizations, and business.

KIRSTEN PRESTON HINSDALE

Vice President for Research and Development for Validated Instruction Associates, Inc., Ms. Preston possesses a wide range of experience in the systems approach to training task analysis, work measurement and work simplification, job design, program development and evaluation, and curriculum design, validation, and evaluation. She has served as Project Director for the Illinois Regional Resource Center Diagnostic Teaching Project; Manager of Data Analysis for the U.S. Navy Leadership and Management Education and Training Project; Co-Manager of the U.S. Navy Human Resource Management School Curriculum Development and Evaluation Project; and Coordinator for the Michigan Department of Social Services Public Service Careers Training Program and Assistance Payments Staffing Standards Study.

Additionally, Ms. Preston served as a staff member during the VIA designed and implemented programs for the faculties of William Paterson College of Wayne, New Jersey, and the Michigan Association of Independent Colleges and Universities.

Among her publications are:

with Cook, J.W., Morreau, L.E., Smith, P.J., and Zink, J. The Illinois-RRC Diagnostic Teaching Model: A Systems Approach to Individualized Assessment and Programming for Children with Unexplained Handicaps. Peoria, Illinois: RRC #7, 1976.

with Zink, J. Human Resource Management Instructor and Specialist Training Curriculum, HRM School, NAS, Memphis. Memphis, Tenn.: Chief of Naval Education and Training, 1975.

Work Measurements and Workload Standards as Management Tools for Public Welfare. Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1974.

PAULA SMITH

Ms. Smith is an instructor of Special Education at Illinois State University where she coordinates and supervises graduate students in the Educational Evaluation Unit. She is also employed as a technical consultant to the Illinois Regional Resource Center, a statewide project for children with unexplained handicaps. Through this association she has acted as a consultant to Validated Instruction Associates, Inc. in the development of the Illinois RRC Diagnostic Teaching Model and in the design and presentation of in-service training for Diagnostic Teachers throughout Illinois. As a result of this effort, Ms. Smith coauthored the _Illinois RRC Diagnostic Teaching Model: A Systems Approach to Assessment and Programming for Children with Unexplained Handicaps._

Upon graduation from Illinois State University with a B.S. in Ed. (1969) and an M.S. in Ed. (1971), Ms. Smith has accumulated a wide range of experiences. In addition to teaching in regular elementary classrooms and classrooms for learning disabled children, she has supervised a multi-county Learning Diabilities Program in which she managed human and financial resources, coordinated program policies, and performed numerous public relations functions. Among her accomplishments in this connection were the design and implementation of selection criteria for L.D. teachers, placement criteria for handicapped children, and in-service workshops.

J. ZINK

Dr. J. Zink is the President of Validated Instruction Associates, Inc. Prior to coming full-time to VIA, where he is a member of the Board of Directors, Dr. Zink was Associate Professor of Humanities and Coordinator of The Institute For Innovation and Continuing Education at The William Paterson College of New Jersey.

A Doctor of Philosophy in Medieval Languages and Literatures from the University of Detroit, Dr. Zink completed a year of Post-Doctoral work at the University of Michigan in the Graduate School of Business at the Center for Programmed Learning, where he later became a Senior Editor and Staff Member.

Dr. Zink is the author of dozens of mediated instructional sequences including Pronouncing Chaucer's Language, which has become a standard text for students of Chaucer at many prestigious colleges and universities in this country and Canada. In 1975 Dr. Zink produced Opera One, a thirteen one-hour, criterion-referenced color television series broadcast over fifteen cablevision stations in the North Jersey-Metropolitan New York area to an audience of two hundred thousand viewers. In April of 1975 Opera One was awarded a national Exceptional Achievement Award by the Council for the Advancement and Support of Education.

During his professional career Dr. Zink has served as an educational consultant to the United States Navy, the Association of Independent Colleges and Universities in Michigan, the State of Michigan, the State of Illinois, the State of New Jersey, the University of Richmond, the University of Michigan, the State Prison of Southern Michigan, and Walden University, as well as TITLE IV B projects in the State of New Jersey and TITLE VI B projects in the State of Illinois.

WORKSHOP SCHEDULE

WORKSHOP FOR DIAGNOSTIC TEACHERS

August 9-20, 1976

Monday, August 9

8:30 Coffee and Danish

9:00 Welcome and Greetings by
Dr. Harold Berjohn
Director, RRC #7

Dr. James W. Cook, Chairman
Validated Instruction Associates, Inc.

Introductions: Staff and Participants

9:15 Presentation
"IRDTM: An Overview"
Dr. J. Zink, Workshop Director,
President, Validated Instruction Associates, Inc.

12:00 Lunch

1:00 Phase I: IRDTM/Initial Information Gathering

Presentation: "An Introduction To Flowcharting"
Ms. Kirsten Preston-Hinsdale, Workshop Coordinator,
Vice President for Research and Development
Validated Instruction Associates, Inc.

Flowcharts 1.1-1.5 Walkthrough

2:00 Role Play/Demonstration (1.5.1)
"The Sending Teacher Conference"
Sending Teacher: Ms. Millie Moser
Diagnostic Teacher
RRC #7

August 9, Continued

Diagnostic Teacher: Ms. Colleen Matthews
Deaf Educator
RRC #7

Feedback and Discussion

4:00 Closure

5:00 Cocktails at the home of
Ms. Dea Boker
Assistant Director, RRC #7

Tuesday, August 10

8:30 Coffee and Danish

9:00 Presentation (1.5.3)
"What to Look for During the Child Interview"
Ms. Colleen Matthews
Deaf Educator
RRC #7

Feedback and Discussion
Discussion Leader: Ms. Paula Jean Smith
Instructor, Special Education
Illinois State University

10:00 Presentation (1.6)
"What the Social Worker looks for during the Home Visit"
Mr. Michael Wasson
Social Worker
RRC #7

Flowcharts 1.7-1.9 Walkthrough
Ms. Preston-Hinsdale

12:00 Lunch

1:00 Phase II: IRDTM/Diagnosis
Dr. Zink:
Introduction of Team Alpha, Beta, Delta, Gamma
Team Concept Explained
Raw Data for Workshop Case Study Distributed

Flowchart 2.1 Walkthrough
Diagnostic Team Objectives: Ms. Preston-Hinsdale
Team Activity: Write Diagnostic Team Objectives
for Workshop Case Study

Discussion and Feedback

Flowchart 2.2 Walkthrough
Change Plan: Ms. Preston-Hinsdale

3:30 Viewing: Classroom Management of Disruptive Behavior
(Videotape/34 minutes)

4:00 Closure

Wednesday, August 11

8:30 Coffee and Danish .

9:00 Presentation (2.2)
"Writing Behavioral Objectives"
Dr. Lanny Morreau
Assistant Professor of Special Education
Illinois State University

Team Activity: Write Behavioral Objectives

Discussion and Feedback

12:00 Lunch

1:00 Presentation (2.2)
"Using Reinforcers and Reinforcement Strategies"
Dr. Lanny Morreau

2:00 Team Activity: Write a Change Plan for the Workshop Case Study

Discussion and Feedback

3:30 Presentation (2.2)
"Behavioral Charting"
Ms. Paula Jean Smith

4:00 Closure

Thursday, August 12

8:30 Coffee and Danish

9:00 Flowcharts 2.3-2.4 Walkthrough
Ms. Preston-Hinsdale

9:30 Presentation (2.5)
"Selecting and Administering Formal Diagnostic Tests"
Ms. Paula Jean Smith

11:30 Discussion and Feedback

Participant Examination of a Display of Formal Diagnostic Testing Materials

12:00 Lunch

1:00 Team Activity: Interpret Formal Diagnostic Test Results of the Workshop Case Study (including item analysis)

Discussion and Feedback

Discussion Leader: Ms. Paula Jean Smith

4:00 Closure

5:00 Cookout/Grand View Drive

Friday, August 13

8:30 Coffee and Danish

9:00 Presentation (2.6)
"Selecting and Administering Informal Diagnostic Tests"
Ms. Millie Moser
Ms. Sherry LaCasse, (Diagnostic Teacher, ISU)
Ms. Colleen Matthews, Deaf Educator, RRC #7

10:30 Discussion and Feedback
Discussion Leaders: Dr. Morreau and Ms. Smith

12:00 Lunch

1:00 Team Activity: Based on Formal Test Results and Item Analysis, Suggest Informal Tests and Procedures for Workshop Case Study

2:00 Discussion and Feedback
With critique by Dr. Morreau, Ms. Smith, Ms. Moser, Ms. LaCasse, and Ms. Matthews

3:00 Closure

Monday, August 16

8:30 Coffee and Danish

9:00 Flowchart 2.7 Walkthrough
Formal/Informal Consultative Staffing
Ms. Preston-Hinsdale

9:20 Team Activity: (2.8) Complete A, Diagnostic Summary
for the Workshop Case Study

11:00 General Group Discussion and Feedback
"Problems and Solutions"

12:00 Lunch

1:00 Phase III: IRDTM/Program Development and Testing

Flowcharts 3.1-3.2 Walkthrough

Long Range/Short Range Program Objectives
Ms. Preston-Hinsdale

2:00 Group Discussion and Feedback

3:00 Team Activity: (3.3) Brainstorm
A Task Analysis based on Provided and Accumulated
Data on the Workshop Case Study

Group Discussion and Feedback

4:00 Closure

Tuesday, August 17

8:30 Coffee and Danish

9:00 Team Activity: (3.4) Devise An Initial Program Prescription for the Workshop Case Study by

a) Identifying, Selecting, and/or Devising Instructional Strategies (3.4.1) from a list provided;

b) Select and Devise Reinforcement Strategies (3.4.2); and

c) Determine Optimal Learning Environment and Teaching Strategies (3.4.3).

10:00 Group Discussion and Feedback

10:30 Flowchart 3.5-3.7 Walkthrough
Based on Data Supplied by Team Activity for 3.4 Testing, Revising, and Finalizing Program Prescriptions, Including Placement and Implementation Plans
Ms. Preston-Hinsdale

12:00 Lunch

1:00 Team Activity: (3.8) Construct an Individual Behavioral Ladder for Three Behavioral Objectives from the Workshop Case Study

2:00 Group Discussion and Feedback

2:30 Flowchart 3.9 Walkthrough
Follow-Up Services, and Post Placement Data Collection
Ms. Preston-Hinsdale

3:00 Team Activity: (3.10) Write Placement and Follow-Up Activities for the Individual Educational Plan for the Workshop Case Study

3:30 Group Discussion and Feedback

4:00 Closure

Wednesday, August 18

8:30 Coffee and Danish

9:00 Phase IV: IRDTM/Transition

Flowchart 4.1 Walkthrough
Assessing the Child's Readiness for Exit
Ms. Colleen Matthews

10:00 Role Play/Demonstration (4.2)
"The Receiving Teacher Conference - Adapting the IEP to his/her Constraints"

Diagnostic Teacher: Ms. Millie Moser
Receiving Teacher: Dr. Charles Alcorn
School Psychologist
RRC #7

11:00 Group Discussion and Feedback
Discussion Leader: Dr. Alcorn

12:00 Lunch

1:00 Video Taped Role Plays (4.3)
"Training the Program Implementers, or Co-opting the Receiving Teacher"

Receiving Teachers: Mr. Michael Wasson
Dr. Charles Alcorn
Ms. Millie Moser
Ms. Sherry LaCasse
Ms. Dea Baker
Ms. Colleen Matthews

Diagnostic Teachers: Workshop Participants

3:00 Videotape Viewing
Group Discussion and Feedback

4:00 Closure

Evening Assignment:
Walkthrough Flowcharts 4.4-4.7

Thursday, August 19

8:30 Coffee and Danish

9:00 Questions and Answers 4.4-4.7

9:15. Phase V: IRDTM/Follow-Up

Flowchart 5.1 Walkthrough
Program Implementation Follow-Up
Mr. Thomas Borkowski

Flowchart 5.2 Walkthrough
Social Work Services Follow-Up
Mr. Michael Wasson

11:00 Group Discussion and Feedback

12:00 Lunch

1:00 Flowcharts 5.3-5.11 Walkthrough
Including Information on the Follow-Up of the Workshop Case Study which is based on the Actual Case from the RRC #7 Files
Ms. Preston-Hinsdale

3:00 Closure

5:00 Cocktail Party at Jumer's Castle Lodge sponsored by
Validated Instruction Associates, Inc.

6:30 Group Dinner at Jumer's (optional)

Friday, August 20

:30	Coffee and Danish
[illegible]	Summary and Evaluation Dr. J. Zink
	Workshop Evaluation Staff Evaluation Suggestions for Follow-Up Activities General Group Discussion
12:00	Lunch and Closure

ACKNOWLEDGEMENTS

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Dr. Nelson Ashline	Illinois Office of Education
Dr. Harold Berjohn	Regional Resource Center #7
Dr. Larry Betterman	Educational Regional Association
Ms. Diane Blackwell	Regional Resource Center #7
Mr. Elwood Bland	Bureau of Education for the Handicapped
Mr. Thomas Borkowski	Regional Resource Center #7
Dr. Robert Bowen	Western Illinois Association
Dr. Mary Voss Budzik	Lake-McHenry
Ms. Gloria Calovini	Illinois Office of Education
Ms. Rosalie Carter	Regional Resource Center #7
Dr. Reuben Chapman	Validated Instructions
Ms. Barbara Cook	Validated Instructions
Mr. Howard Falk	Area Services Project
Mr. Joe Fisher	Illinois Office of Education
Mr. Larry Goldsmith	Southern Illinois Association for Low-Incidence Handicapped
Dr. Dean Hage	Illinois State University

Dr. Norm Howe	Bureau of Education for the Handicapped
Ms. Paula Jacko	Regional Resource Center #7
Dr. Wayne Johnson	CORRC
Mr. Wendell Jones	West Suburban Association
Ms. Sherry LaCasse	Regional Resource Center #7
Mr. Lloyd Lehman	Regional Service Association
Ms. Nora Loukides	Validated Instructions
Mr. Paul Loukides	Validated Instructions
Mr. Jerry Maring	Northwestern Illinois Association
Ms. Colleen Matthews	Regional Resource Center #7
Dr. J. H. McGrath	Illinois State University
Ms. Millie Moser	Regional Resource Center #7
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Dr. Sam Price	Illinois State University
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Mr. Robert Van Dyke	South Metropolitan Association
Mr. Michael Wasson	Regional Resource Center #7

THE ILLINOIS REGIONAL RESOURCE CENTER

DIAGNOSTIC TEACHING MODEL:

A Systems Approach to Assessment and Programming for Children with Unexplained Handicaps

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Section 1.

INTRODUCTION TO THE ILLINOIS REGIONAL RESOURCE CENTER DIAGNOSTIC TEACHING MODEL

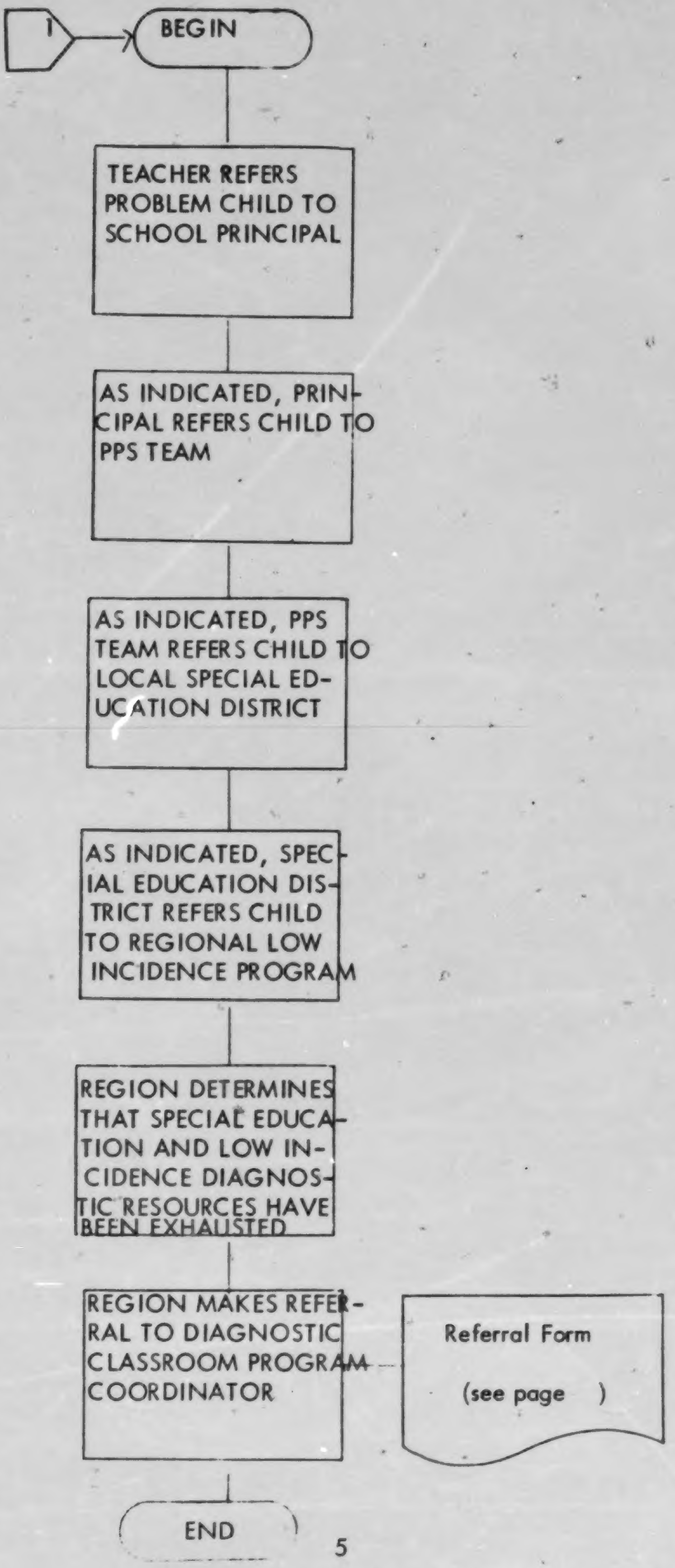
INTRODUCTION TO THE ILLINOIS RRC DIAGNOSTIC TEACHING MODEL

Purpose

The Illinois-RRC Diagnostic Teaching Model (IRDTM) was developed to incorporate both the best practices of master performer diagnostic teachers and current state-of-the-art techniques in the field of Special Education. The purpose of the model is to provide a means through which a specific subset of the handicapped population--children with unexplained handicaps--may be helped to realize their full potential through complete and accurate assessment, individualized educational planning, optimal placement, and short and long range follow-up. As such, the model fully addresses a number of current legislative concerns, including the treatment of the child in the "least restrictive environment," the use of the Individual Educational Plan, and the decentralization of high quality, specialized services to the handicapped.

Target Population

The target population of the IRDTM is the population of children, age 3 to 21, with "unexplained" learning problems. These are children for whom all local and regional avenues of diagnosis have been exhausted and who remain problematic in their current placements in terms of diagnosis or educational programming. The severity of the handicap (e.g., profound retardation, blind/deaf, etc.) is not the criterion for acceptance into the program. It is rather the presence of an unusual combination of physical, psychological, sensory, or educational handicaps in need of further diagnosis or alternative programming which indicate the suitability of a referred child for program acceptance. Figure 1, "Origination of Diagnostic Classroom Referrals," shows the process through


1
BEGIN
TEACHER REFERS PROBLEM CHILD TO SCHOOL PRINCIPAL
AS INDICATED, PRINCIPAL REFERS CHILD TO PPS TEAM
AS INDICATED, PPS TEAM REFERS CHILD TO LOCAL SPECIAL EDUCATION DISTRICT
AS INDICATED, SPECIAL EDUCATION DISTRICT REFERS CHILD TO REGIONAL LOW INCIDENCE PROGRAM
REGION DETERMINES THAT SPECIAL EDUCATION AND LOW INCIDENCE DIAGNOSTIC RESOURCES HAVE BEEN EXHAUSTED
REGION MAKES REFERRAL TO DIAGNOSTIC CLASSROOM PROGRAM COORDINATOR
Referral Form
(see page)
END

which children are referred to the Diagnostic Classroom. Charts 1.1 - 1.9, pp. 28 further depict the process through which the decision to provide services to a referred child is made.

Features of the IRTDM

While many of the principles and procedures included in the IRTDM are widely used in special education in general and in diagnostic classrooms in particular, they are combined in the IRTDM to produce a unique and thorough system for maximizing services delivery to children with unexplained handicaps. The remainder of this chapter presents an overview of the major features of the IRTDM.

1. The model emphasizes diagnosis rather than remediation. An overriding goal of the IRTDM is to facilitate the academic, physical, and social functioning of its target population of exceptional children. Since this is not best accomplished through removal of the child from his or her normal environment for lengthy remediation, the model stresses a brief period of in-depth diagnosis and trial programming which usually lasts no longer than six weeks. During this time, the referred child is fully diagnosed and an Individual Education Plan is developed and tested. After the plan is finalized, the child is returned to his or her original placement (or as indicated, a more appropriate placement) and program implementation becomes the responsibility of the child's receiving teacher supported by follow along consultation from the Diagnostic Teacher.
2. The model employs a team approach to services delivery. The team concept is widely used across various services delivery systems and has been well-substantiated both as a cost-effective use of manpower and an effective

means of services delivery. The IRTDM, when fully staffed, uses a Diagnostic Team consisting of one or more diagnostic teachers, a consulting diagnostic teacher, a team social worker, a team psychologist, and two or more team specialists, such as a speech therapist, vision educator, media specialist, and/or deaf educator. The roles of these team members, as well as those of supportive staff, are implicit in the flowcharts in Section 2, and are fully described in Appendix A, "Regional Resource Center Job Descriptions," and Appendix B, "Suggested Qualifications for Diagnostic Teacher." Appendix C, "Alternative Replication Staffing Models," further presents eight options for the composition of the Diagnostic Team, which varies according to the size and resources of the replicating region.

3. The model provides for the delivery of both on-site and in-classroom services. In its comprehensive approach to services delivery--and unlike most other models--the IRDTM accommodates two major branches of services delivery: "on-site" and "in-classroom" services. In on-site services delivery, the Diagnostic Team works primarily with the child's teachers, other sending school staff, and the child's parents in the development and implementation of an Individual Educational Plan for the child in his or her current placement. In-classroom services, on the other hand, involve the acceptance of the child into the Diagnostic Classroom for in-depth diagnosis and trial programming.

Approximately 10% of the children who receive team services are found to need the extensive services of the Diagnostic Classroom. A referred child is placed in the Diagnostic Classroom when, after initial on-site observation and conferences with the sending school staff, it is determined that further medical diagnosis and/or continued on-site services will not fully suffice to diagnose the child's handicapping conditions.

The same general procedures are employed for the delivery of both on-site and in-classroom services. On-site services, however, usually involve less intense team involvement and more specialized concentration on specific handicaps. Also, it is often the case with on-site services that while diagnosis has been adequate, the child's teacher has skill deficiencies which prevent him or her from effectively dealing with the child. In these cases, the team concentrates on training the child's teacher in appropriate methods, techniques, and materials usage, thereby promoting effective programming for the child in his or her current classroom placement. Thus, by offering an alternative to placement in the Diagnostic Classroom, the IRDTM further facilitates the child's development in the least restrictive environment.

4. The model is procedural. The IRDTM specifies in detail the procedures and decision-making guidelines to be used from the time the child is first referred to the Diagnostic Team through annual follow-up of the child as he or she progresses through the educational system. The model organizes these procedures and decision-making guidelines into five discrete phases, including:

Phase I: Initial Information-Gathering, which specifies procedures for a) the collection of historical and current information on the child (medical, academic, psychological, and social), b) the preliminary assessment of the need for team services, c) on-site conferences with sending school staff, and d) on-site observation of the child;

Phase 2: Diagnosis, which provides guidelines for a) informal and formal testing and observation by the Diagnostic Team, b) the use of medical testing by "consultants," c) the evaluation of diagnostic data, and d) the formulation of diagnostic conclusions;

Phase 3: Program Development and Testing, which provides procedures for a) setting objectives, b) testing instructional materials and strategies, and c) writing the child's Individual Educational Plan;

Phase 4: Transition, which presents procedures for a) the adaptation of the Individual Educational Plan to the reality constraints of the receiving school, b) training the child's parents and receiving teacher in program implementation, and c) preparing the child for exit; and

Phase 5: Follow-up, which specifies the procedures for a) ongoing consultation to the child's parents and receiving teacher, b) the collection of formal and informal follow-up data, and c) the evaluation of the Individual Educational Plan and total services delivery system.

The procedures and decision-making guidelines for each of the above phases of the IRDTM are presented in full in the ensuing section, "Flowcharts for the IRDTM."

5. The model uses a wide range of human resources to ensure that diagnosis is comprehensive. Critical to the successful implementation of the IRDTM are the services and inputs of a wide range of human resources. Thus, the model leans heavily on the use of a number of professional and paraprofessional "consultants" and involves the child's family in each of the five model phases.

The rationale for the involvement of the child's parents and siblings in the IRDTM is apparent: the model takes a holistic approach to both diagnosis and programming, and family life represents fully two-thirds of the child's time. In the model the family therefore serves as a primary source of diagnostic information, a touchstone for establishing the directions that diagnosis and programming should take, and a means of program implementation In addition, the model further encourages the full use of this valuable human resource by specifying in detail the procedures for the initial home visit, ongoing social work services, parent training, and parent follow-up.

As mentioned, also highly necessary to model implementation is access by the Diagnostic Team to the services a variety of medical and other consultants. Among these consultants are family doctors, pediatricians, neurologists, psychologists, family counselors, physical therapists, etc. Without access to the services of these and other expert diagnostic personnel, complete, accurate diagnosis cannot occur, and the impact of the IRDTM is seriously undermined. For a complete listing of medical and other consultants, see Appendix D, "Consultants Available to the RRC Team."

6. The model stresses a holistic approach to the individual child. To ensure that all aspects of the child's functioning are fully considered by the Diagnostic Team, the IRDTM incorporates a comprehensive set of diagnostic categories for use as an organizational framework for diagnostic information and program prescriptions. These diagnostic categories, or "diagnostic domains," are:

1) Motor Domain, including:

   a. Gross Motor

   b. Fine Motor

2) Sensory-Perceptual Domain, including:

  - a) Visual Reception
  - b) Visual Perception or Acuity
  - c) Visual Association
  - d) Auditory Reception
  - e) Auditory Perception
  - f) Auditory Association
  - g) Sensory-Motor Skills

3) Academic Domain, including:

  - a) Reading Skills
  - b) Math Skills
  - c) Writing

4) Speech/Language Domain, including:

  - a) Concept Information
  - b) Receptive Language
  - c) Expressive Language
  - d) Language Usage

5) Social-Emotional Domain, including:

  - a) Peer Relationships
  - b) Adult Relationships
  - c) Family Relationships
  - d) Self-concept
  - e) Behaviors

6) Self-Help Domain, including:

  - a) Feeding
  - b) Dressing

c) Toileting

d) Hygiene

The emphasis given to each of the above diagnostic domains depends upon the extent to which a given child's diagnostic and programming needs are concentrated in that domain. In this manner, the individual child's strengths and weaknesses become the frame of reference for both diagnosis and programming.

7. The model is eclectic in its use of theory, diagnostic tests, and educational materials. The IRDTM is not based on any particular child development or psychological theory; nor does it recommend the use of any particular materials or testing devices. Instead, the model assumes that the Diagnostic Team members possess the skill, knowledge, and experience to select and employ various theories, tests, and materials as appropriate to the handicaps and strengths of the individual child.

Lending some structure to this eclectic method of diagnosis and programming are 1) the diagnostic categories described in #6 above, and 2) the decision-making guidelines contained throughout the IRDTM. These guidelines, by directing the Diagnostic Team through a comprehensive series of strategies for diagnosis and programming, provide the parameters within which the composite team skills, knowledge, and experience may be eclectically brought to bear on the needs of the individual child.

8. The model is comprehensive in its approach to diagnosis and programming. Many diagnostic teaching models subscribe to either a traditional, assessment-oriented approach to diagnosis and programming or to the exclusive use of behavior modification. The former approach depends largely on the use of

standardized tests and instructional materials; the latter employs strictly behavioral testing, measurement, and remediation. However, to accommodate treatment of the "whole child," the IRDTM incorporates both. During Phase 1, Initial Information-Gathering, both assessment-oriented and behavioral data on the child are gathered. In Phase 2, Diagnosis, both standardized testing and behavioral testing and observation are used as the need is indicated for the individual child. And in Phase 3, Program Development and Testing, both behavioral and traditional academic means of educational planning and programming are employed, once again, as dictated by the needs of the individual child.

9. The model is self-correcting. The IRDTM contains both formal and informal mechanisms for the evaluation of the Individual Educational Plan and the evaluation and revision of the total services delivery system. The formal mechanism, also called the "Child Tracking System," consists of the collection and analysis of three types of data on children who have received in-classroom services. These are a) Child Follow-Up Data, b) Longitudinal Follow-Up Data, and c) Pre-and-Post-Placement Data, and are described below.

   a) Child Follow-Up Data is collected at 3, 6, 9, and 12 month intervals after the child's exit from the Diagnostic Classroom and measures the extent to which the child has achieved the behavioral objectives established by the Diagnostic Team. Child Follow-Up Data is initially analyzed for each child and used in the revision of the child's behavioral objectives. Because by implication a child's failure is also the Diagnostic Team's failure, this data also provides information useful to the team members in identifying their strengths and weaknesses and in modifying their approaches to diagnosis, programming, and services delivery. Later in time, as the data base accumulates, analyses may be performed to determine the extent to which the total child population, or children with a certain handicap, or children of different ages, etc., achieve the behavioral objectives set for them. This long range evaluation mechanism has numerous implications for the validation and revision of the total services delivery system.

b) Longitudinal Follow-Up Data is collected on the child annually and relates to the child's progression through the educational system and movement toward or away from the goals set for the child. It is used in long range program validation and revision.

c) Pre-and-Post-Placement Data consists of data gathered on the child during Phase 1, Initial Information-Gathering, and later compared to similar data collected during Phase 5, Follow-Up. Included in this category are pre-and post-placement grades, psychological test scores, achievement test scores, and observational, behavioral, and other data on the child. Because it is not possible to establish uniformity in the types of pre-and post-placement data collected on each child who has received in-classroom services, this component of the Child Tracking System is less formalized than the two components previously mentioned. However, its usefulness should not be underestimated. Particularly important in this connection is the use of pre-placement and post-placement behavioral and observational data. It is often the case that the child's behavior disorders at the time of referral are not evident in the diagnostic classroom setting, where the child is exposed to a completely different set of environmental variables. The one-to-one student-teacher ratio, for example, tends to eliminate many behaviors displayed by the child in a normal classroom setting. By comparing the child's pre-and post-placement behaviors a true measure of the child's progress or regression which is not otherwise available may be obtained.

The informal evaluation mechanism included in the IRDTM consists of two feedback loops. While these feedback loops provide less precise data than does the Child Tracking System, they do have the advantage of providing immediate, and immediately useful, information on the quality of the Individual Educational Plan and the effectiveness of the total services delivery system. Also, unlike the Child Tracking System, the informal evaluation data is gathered on children who have received either on-site or in-classroom services. The informal feedback loops are:

a) Parent Follow-Up, which is conducted one month after program implementation and examines 1) the degree to which the child's parents are satisfied with the scope and quality of on-site or in-classroom services, and 2) the parents' observations of improvement and regression in the child; and

b) Teacher Follow-Up, which is also conducted one month after program implementation and investigates 1) the child's general adjustment to his or her placement and programming, 2) areas of improvement and regression observed in the child, 3) the usefulness of the Individual Educational Plan, and 4) overall receiving teacher satisfaction with the quality and scope of team services.

The information obtained from Parent and Teacher Follow-Up provides immediate feedback on the effectiveness of team services, the value of the Individual Educational Plan, and the child's initial adjustment, improvement, or regression. Like the Child Follow-Up Data, this information may be used by the Diagnostic Team to isolate the domains in which the team is particularly weak or needs additional training, and to adjust their approaches to diagnosis and programming accordingly. It may also be used to provide more immediate feedback on the total services delivery system than does the Child Tracking System, and to serve as a basis for interim program revision. Then, as the data from the Tracking System accumulates, the Parent and Teacher Follow-Up data may be used as corroborative information to substantiate the outcomes of the Child Follow-Up and Longitudinal data analyses.

10. The model uses child adjustment, achievement, and movement toward the established educational goals as the major criteria for system success.

    As can be surmissed from the previous section, data from the child (e.g., behavioral objectives achievement) and data about the child, (e.g., subsequent placements, adjustments, movement toward normalization) comprise the heart of the informal and formal evaluation systems. Since the model is based on a holistic approach to the individual child, it follows that the true success of the model, the team, the program, and each Individual Educational Plan should be measured in terms of the outcomes of the system for the children served. Thus, as with the emphasis on individualization and eclecticism in diagnosis and prescription, the child becomes the pivotal point for system evaluation.

11. The model is responsive to the needs, strengths, and constraints of those for program implementation. Built into the IRDTM are procedures designed to maximize the probability that each child's Individual Educational Plan will be implemented -- i.e., will meet the needs of those who must use it as well as the child's needs. These procedures include:

during Phase 1:

a) a determination of the questions that both the child's sending school staff and parents would like to have answered as a result of diagnosis of the child, and

b) conferences with sending school staff to ascertain their reality constraints for program implementation in terms of time, materials, etc.;

during Phases 2 and 3:

c) the ongoing use of the sending/receiving school staff and the child's parents as "reality checks" to ensure that the course of diagnosis and programming is consistent with their needs and objectives for the child;

during Phase 4:

d) the adjustment of the Individual Educational Plan to reflect the strengths and constraints of the child's parents and receiving school staff, and

e) the training of parents, teachers, and other resource persons in program implementation; and

during Phase 5:

f) assistance in program implementation,

g) the provision of follow-up services to all program implementers, and

h) the revision of program prescriptions based on the actual success of the Individual Educational Plan as reported by parents and teachers at the time of the one month follow-up.

Summary

As is apparent from the above narrative, the IRDTM incorporates the best practices and principles used in special education, with special emphasis on children with unexplained handicaps. The full use of this model, and faithful attention to the details on the following flowcharts, will ensure the maximization of services delivery to children with unexplained learning problems. In addition, it will address a number of legislative concerns such as treatment of the child in the least restrictive environment, the use of the Individual Educational Plan, and the ultimate goal of normalization and improved services to the handicapped.

SECTION 2

FLOWCHARTS FOR THE ILLINOIS RRC DIAGNOSTIC TEACHING MODEL

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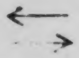
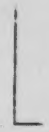
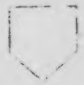
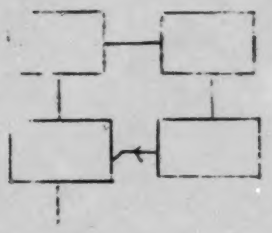
FLOWCHART SYMBOLS

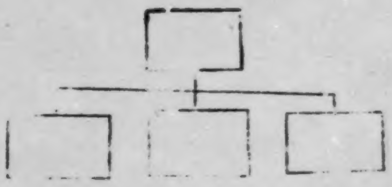
The purpose of the following flowcharts is to outline in a visually understandable format the flow of the Illinois RRC Diagnostic Teaching Model. The charts are organized into five major sections including, Phase 1: Initial Information-Gathering, Phase 2: Diagnosis, Phase 3: Program Development and Testing, Phase 4: Transition, and Phase 5: Follow-Up.

The charts should be read from left to right and top to bottom. The symbols are as follows:

	Arrows:	Used to indicate the direction of the flow.
	Process:	Used to indicate a task.
	Bracket:	Used to indicate cross-references to a task.
	Decision:	Used to indicate a decision point in the process.
	Input/Output:	Used to indicate the input or output of information.
	Connector:	Used to indicate the beginning of a chart and to connect process.
	Terminal:	Used to indicate the beginning or end of a process.

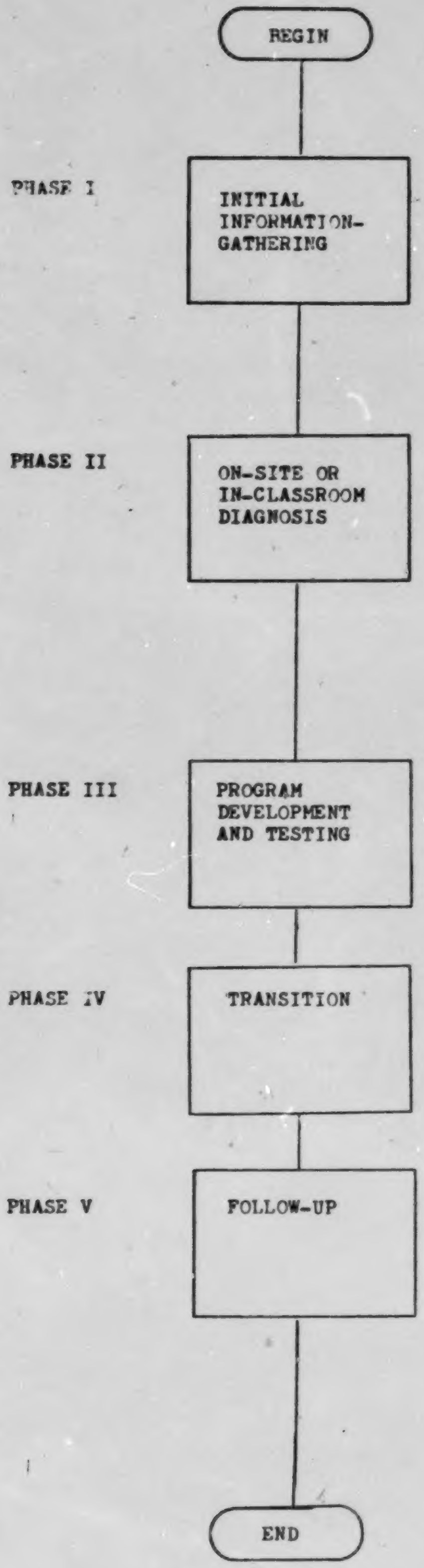


Horizontal or Vertical Branching: Used to indicate sequential subtasks.



Parallel Branching: Used to indicate tasks performed simultaneously.

OVERVIEW OF THE ILLINOIS RRC DIAGNOSTIC TEACHING MODEL, PHASES I - V


BEGIN
PHASE I
INITIAL INFORMATION-GATHERING
PHASE II
ON-SITE OR IN-CLASSROOM DIAGNOSIS
PHASE III
PROGRAM DEVELOPMENT AND TESTING
PHASE IV
TRANSITION
PHASE V
FOLLOW-UP
END

Objectives

1. To determine the child's technical eligibility for team services.
2. To gather, through conferences, classroom observation, and a review of existing records, all historical and current medical, academic, and social information on the referred child.
3. To determine the child's need for on-site services or Diagnostic Classroom placement.

• • • • •

1. To conduct, through the use of formal and informal tests, classroom observation, and medical and other consultants, a complete diagnosis of the child's handicaps across all diagnostic domains.
2. To devise and implement Diagnostic Team Objectives.
3. To devise and implement a Change Plan.
4. To organize and evaluate all diagnostic information.
5. To form diagnostic conclusions.

• • • • •

1. To establish long and short range program objectives.
2. To devise, test, modify, retest, and finalize program prescriptions.
3. To devise placement recommendations and follow-up plans.

• • • • •

1. To prepare the child for exit.
2. To adapt the Individual Educational Plan to the resources and constraints of the receiving school.
3. To train the child's parents and current or receiving teacher in program implementation.

• • • • •

1. To assist in initial program implementation.
2. To provide post-placement consultation and assistance to the child's parents, teachers, and other program implementers.
3. To gather and analyze informal evaluation data for use in program evaluation and revision.
4. To gather and analyze formal evaluation data for use in the revision of the Individual Behavioral Ladder and in program evaluation and revision.

• • • • •

Phase I: INITIAL INFORMATION-GATHERING

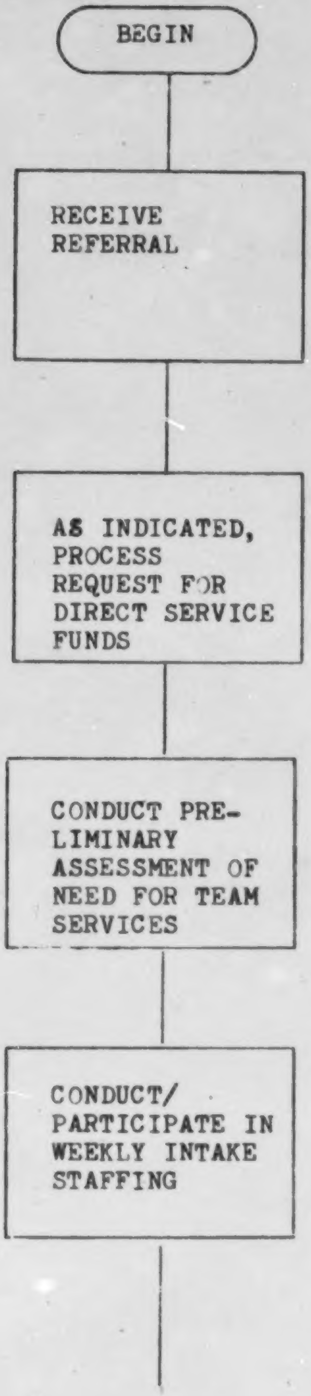
Objectives:

1. To determine the child's technical eligibility for team services.
2. To gather, through conferences, classroom observation, and a review of existing records, all historical and current medical, academic, psychological, and social information on the referred child.
3. To determine the child's need for on-site services or Diagnostic Classroom placement.

Initiating Event: Receipt of referral

Terminating Event: Intake/Placement Staffing

OVERVIEW OF PHASE 1: INITIAL INFORMATION-GATHERING


BEGIN
RECEIVE REFERRAL
AS INDICATED, PROCESS REQUEST FOR DIRECT SERVICE FUNDS
CONDUCT PRELIMINARY ASSESSMENT OF NEED FOR TEAM SERVICES
CONDUCT/ PARTICIPATE IN WEEKLY INTAKE STAFFING

Cf:	Staff:
Chart 1.1	Program Coordinator
Chart 1.2	Program Coordinator
Chart 1.3	Program Coordinator Diagnostic Team
Chart 1.4	Program Coordinator Diagnostic Team

Continued on next page

Phase 1 Overview Chart, Continued

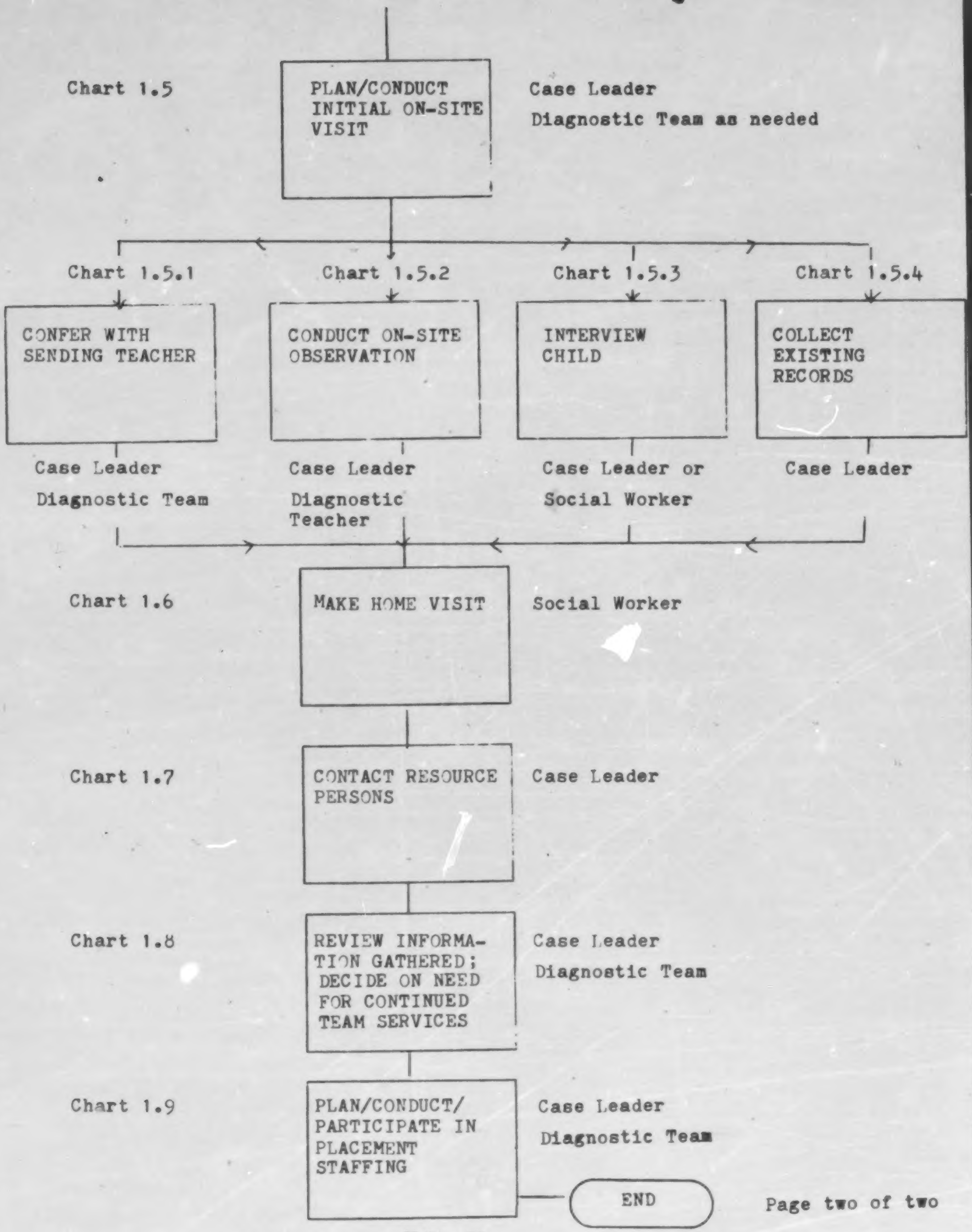


Chart 1.5
PLAN/CONDUCT INITIAL ON-SITE VISIT
Case Leader
Diagnostic Team as needed
Chart 1.5.1
CONFER WITH SENDING TEACHER
Case Leader
Diagnostic Team
Chart 1.5.2
CONDUCT ON-SITE OBSERVATION
Case Leader
Diagnostic Teacher
Chart 1.5.3
INTERVIEW CHILD
Case Leader or
Social Worker
Chart 1.5.4
COLLECT EXISTING RECORDS
Case Leader
Chart 1.6
MAKE HOME VISIT
Social Worker
Chart 1.7
CONTACT RESOURCE PERSONS
Case Leader
Chart 1.8
REVIEW INFORMATION GATHERED; DECIDE ON NEED FOR CONTINUED TEAM SERVICES
Case Leader
Diagnostic Team
Chart 1.9
PLAN/CONDUCT/ PARTICIPATE IN PLACEMENT STAFFING
Case Leader
Diagnostic Team
END

Page two of two

Program Coordinator

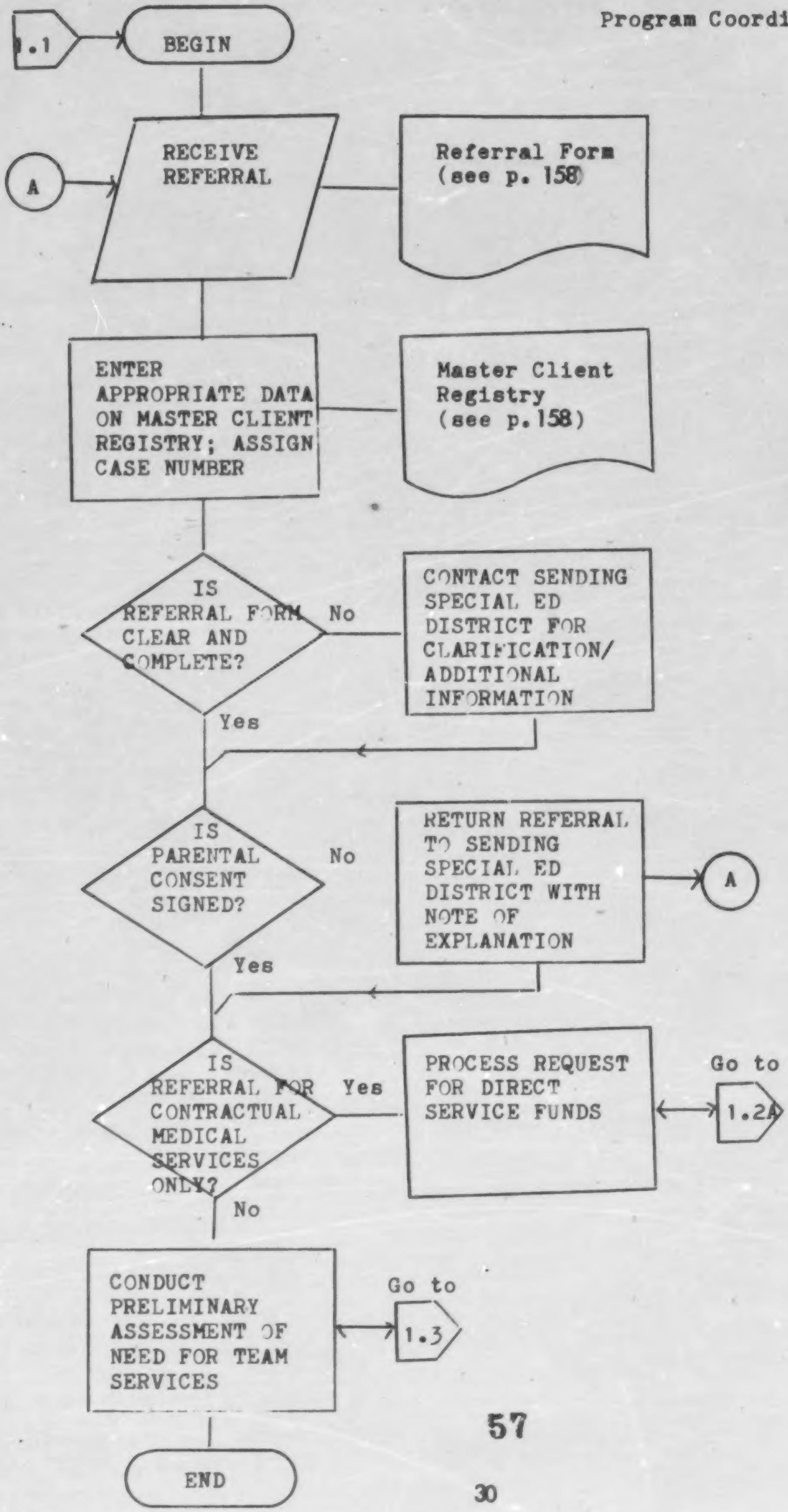
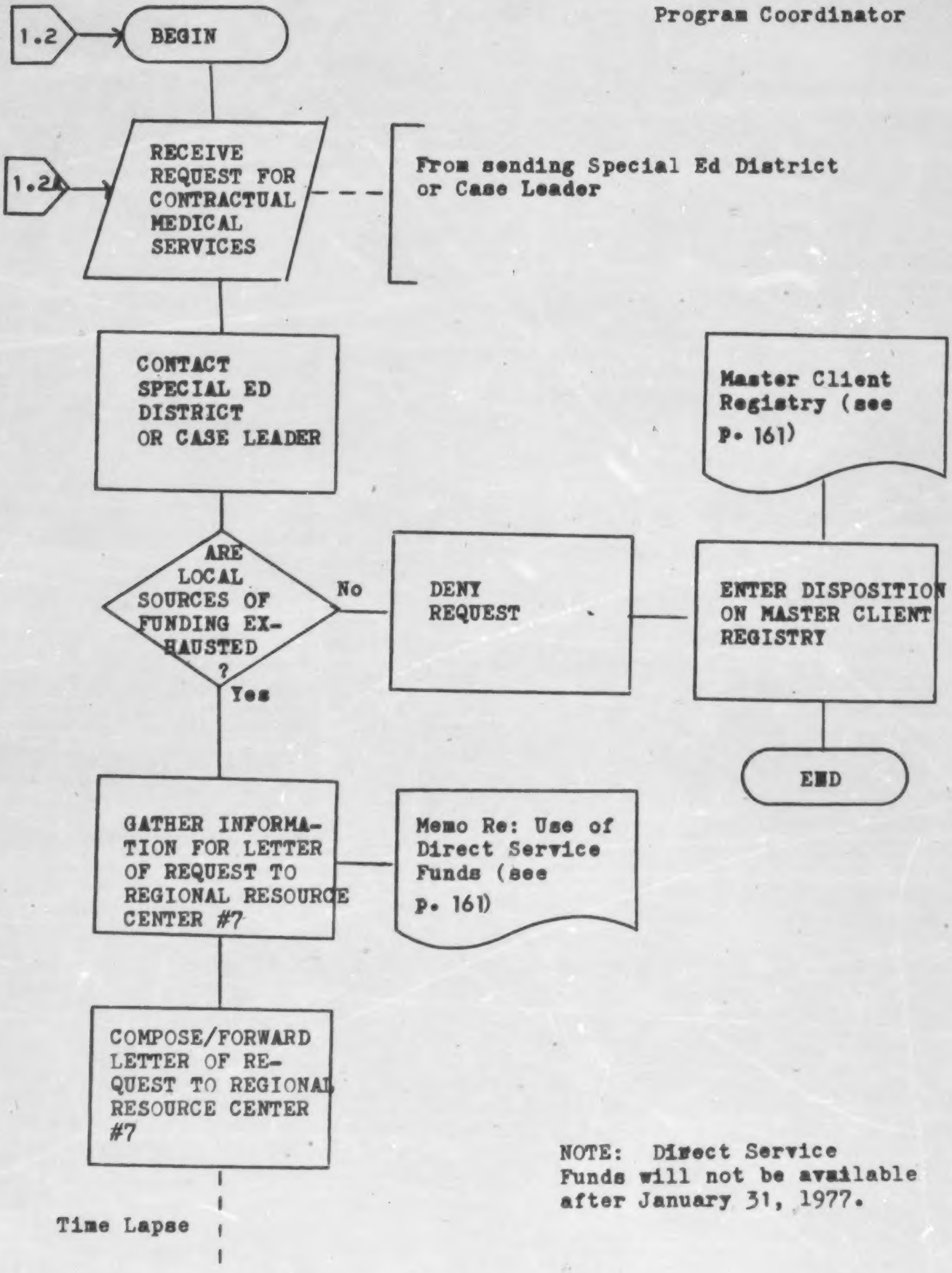

1.1
BEGIN
A
RECEIVE REFERRAL
Referral Form (see p. 158)
ENTER APPROPRIATE DATA ON MASTER CLIENT REGISTRY; ASSIGN CASE NUMBER
Master Client Registry (see p. 158)
IS REFERRAL FORM CLEAR AND COMPLETE?
No
CONTACT SENDING SPECIAL ED DISTRICT FOR CLARIFICATION/ ADDITIONAL INFORMATION
Yes
IS PARENTAL CONSENT SIGNED?
No
RETURN REFERRAL TO SENDING SPECIAL ED DISTRICT WITH NOTE OF EXPLANATION
A
Yes
IS REFERRAL FOR CONTRACTUAL MEDICAL SERVICES ONLY?
Yes
PROCESS REQUEST FOR DIRECT SERVICE FUNDS
Go to
1.2A
No
CONDUCT PRELIMINARY ASSESSMENT OF NEED FOR TEAM SERVICES
Go to
1.3
END

Chart 1.2 PROCESS REQUEST FOR DIRECT SERVICE FUNDS

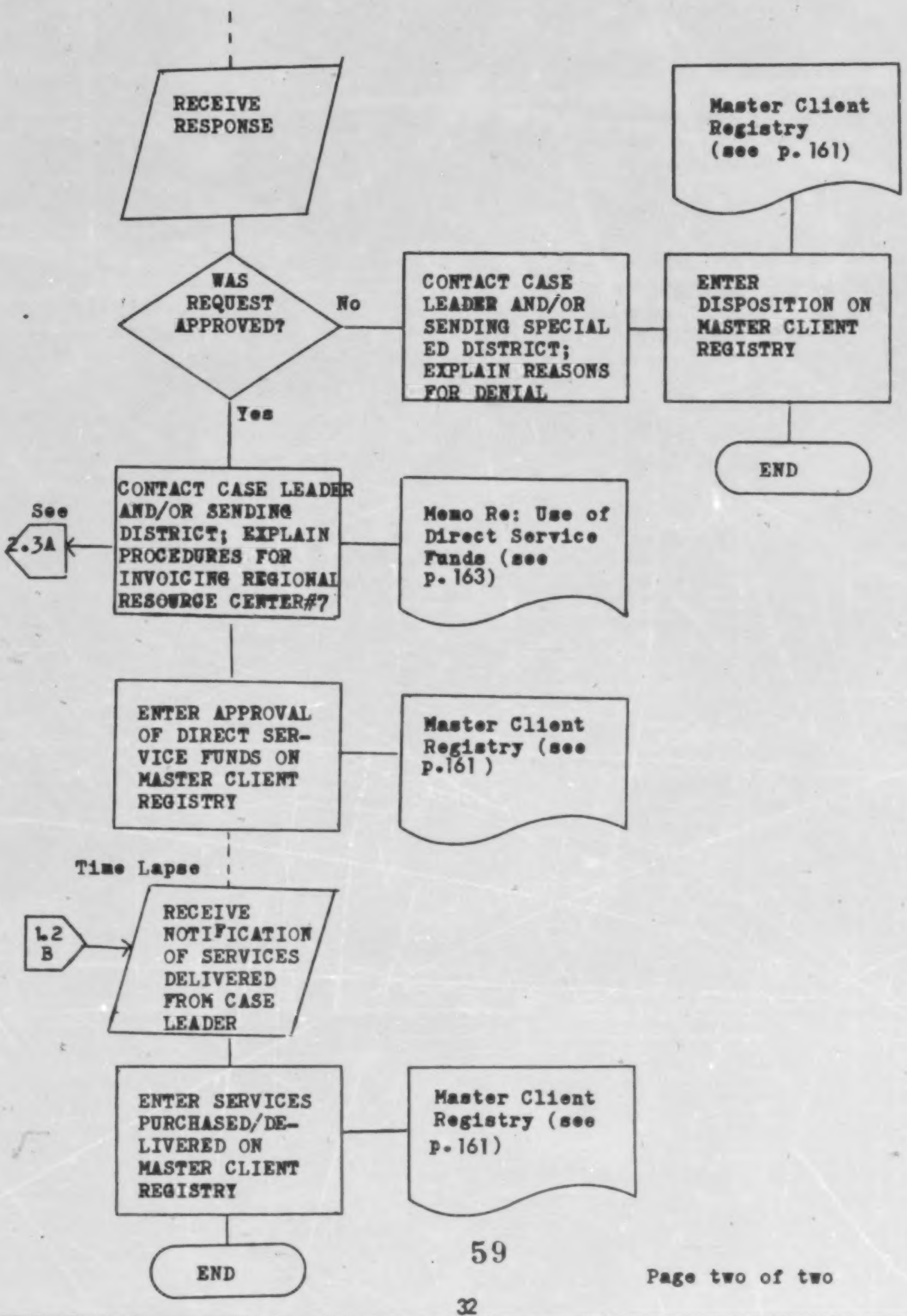
Program Coordinator


1.2
BEGIN
1.2A
RECEIVE REQUEST FOR CONTRACTUAL MEDICAL SERVICES
From sending Special Ed District or Case Leader
CONTACT SPECIAL ED DISTRICT OR CASE LEADER
ARE LOCAL SOURCES OF FUNDING EXHAUSTED ?
No
Yes
DENY REQUEST
Master Client Registry (see p. 161)
ENTER DISPOSITION ON MASTER CLIENT REGISTRY
END
GATHER INFORMATION FOR LETTER OF REQUEST TO REGIONAL RESOURCE CENTER #7
Memo Re: Use of Direct Service Funds (see p. 161)
COMPOSE/FORWARD LETTER OF REQUEST TO REGIONAL RESOURCE CENTER #7
Time Lapse

NOTE: Direct Service Funds will not be available after January 31, 1977.

Continued on next page

Chart 1.2 Continued


RECEIVE RESPONSE
Master Client Registry (see p. 161)
WAS REQUEST APPROVED?
No
CONTACT CASE LEADER AND/OR SENDING SPECIAL ED DISTRICT; EXPLAIN REASONS FOR DENIAL
ENTER DISPOSITION ON MASTER CLIENT REGISTRY
END
Yes
See
2.3A
CONTACT CASE LEADER AND/OR SENDING DISTRICT; EXPLAIN PROCEDURES FOR INVOICING REGIONAL RESOURCE CENTER#7
Memo Re: Use of Direct Service Funds (see p. 163)
ENTER APPROVAL OF DIRECT SERVICE FUNDS ON MASTER CLIENT REGISTRY
Master Client Registry (see p.161)
Time Lapse
1.2 B
RECEIVE NOTIFICATION OF SERVICES DELIVERED FROM CASE LEADER
ENTER SERVICES PURCHASED/DELIVERED ON MASTER CLIENT REGISTRY
Master Client Registry (see p. 161)
END

Page two of two

Chart 1.3 CONDUCT PRELIMINARY ASSESSMENT OF NEED FOR TEAM SERVICES

Program Coordinator

Diagnostic Team

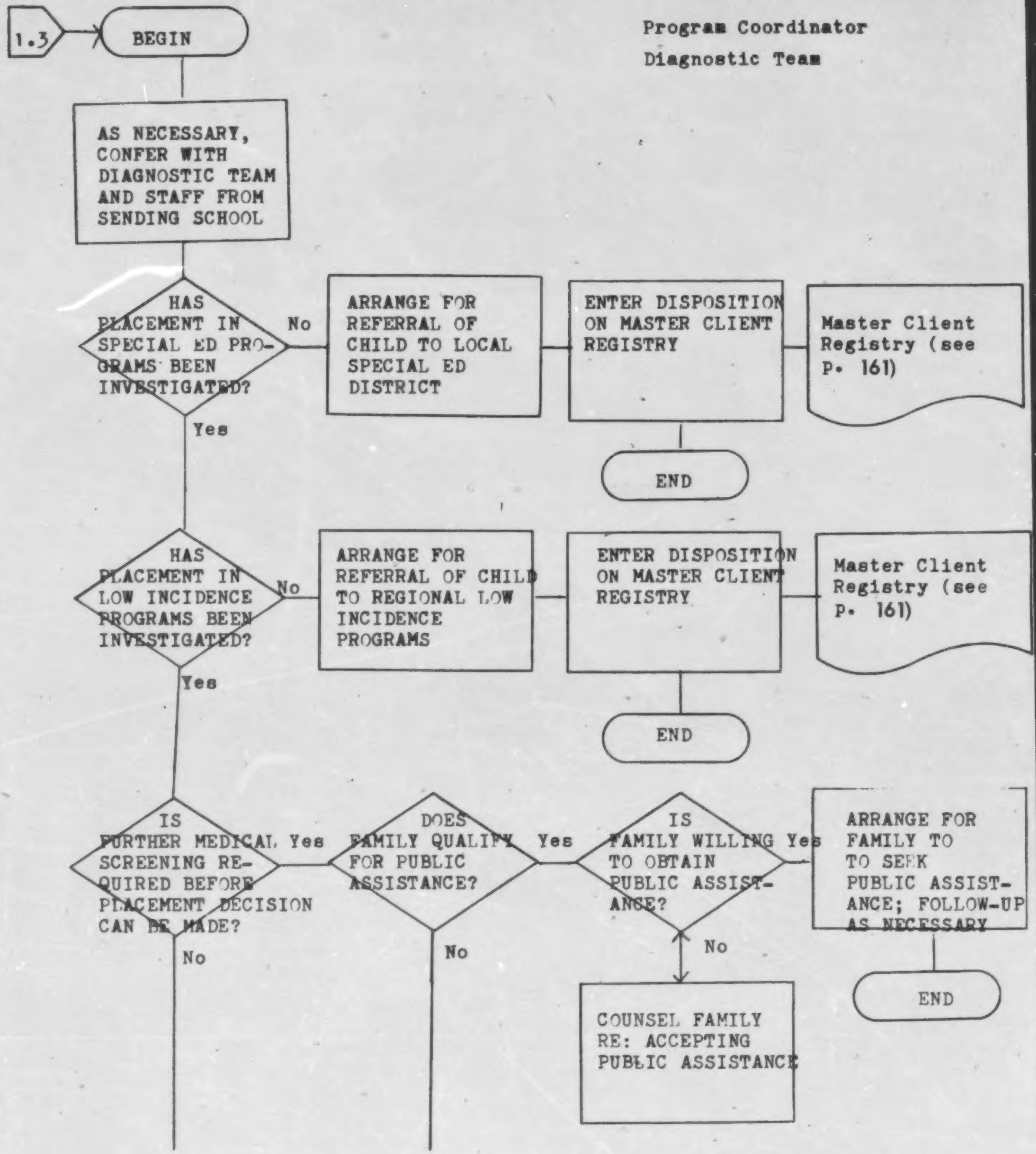

1.3
BEGIN
AS NECESSARY, CONFER WITH DIAGNOSTIC TEAM AND STAFF FROM SENDING SCHOOL
HAS PLACEMENT IN SPECIAL ED PROGRAMS BEEN INVESTIGATED?
No
ARRANGE FOR REFERRAL OF CHILD TO LOCAL SPECIAL ED DISTRICT
ENTER DISPOSITION ON MASTER CLIENT REGISTRY
Master Client Registry (see p. 161)
END
Yes
HAS PLACEMENT IN LOW INCIDENCE PROGRAMS BEEN INVESTIGATED?
No
ARRANGE FOR REFERRAL OF CHILD TO REGIONAL LOW INCIDENCE PROGRAMS
ENTER DISPOSITION ON MASTER CLIENT REGISTRY
Master Client Registry (see p. 161)
END
Yes
IS FURTHER MEDICAL SCREENING REQUIRED BEFORE PLACEMENT DECISION CAN BE MADE?
Yes
DOES FAMILY QUALIFY FOR PUBLIC ASSISTANCE?
Yes
IS FAMILY WILLING TO OBTAIN PUBLIC ASSISTANCE?
Yes
ARRANGE FOR FAMILY TO TO SEEK PUBLIC ASSISTANCE; FOLLOW-UP AS NECESSARY
END
No
COUNSEL FAMILY RE: ACCEPTING PUBLIC ASSISTANCE
No
No

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Chart 1.3 Continued

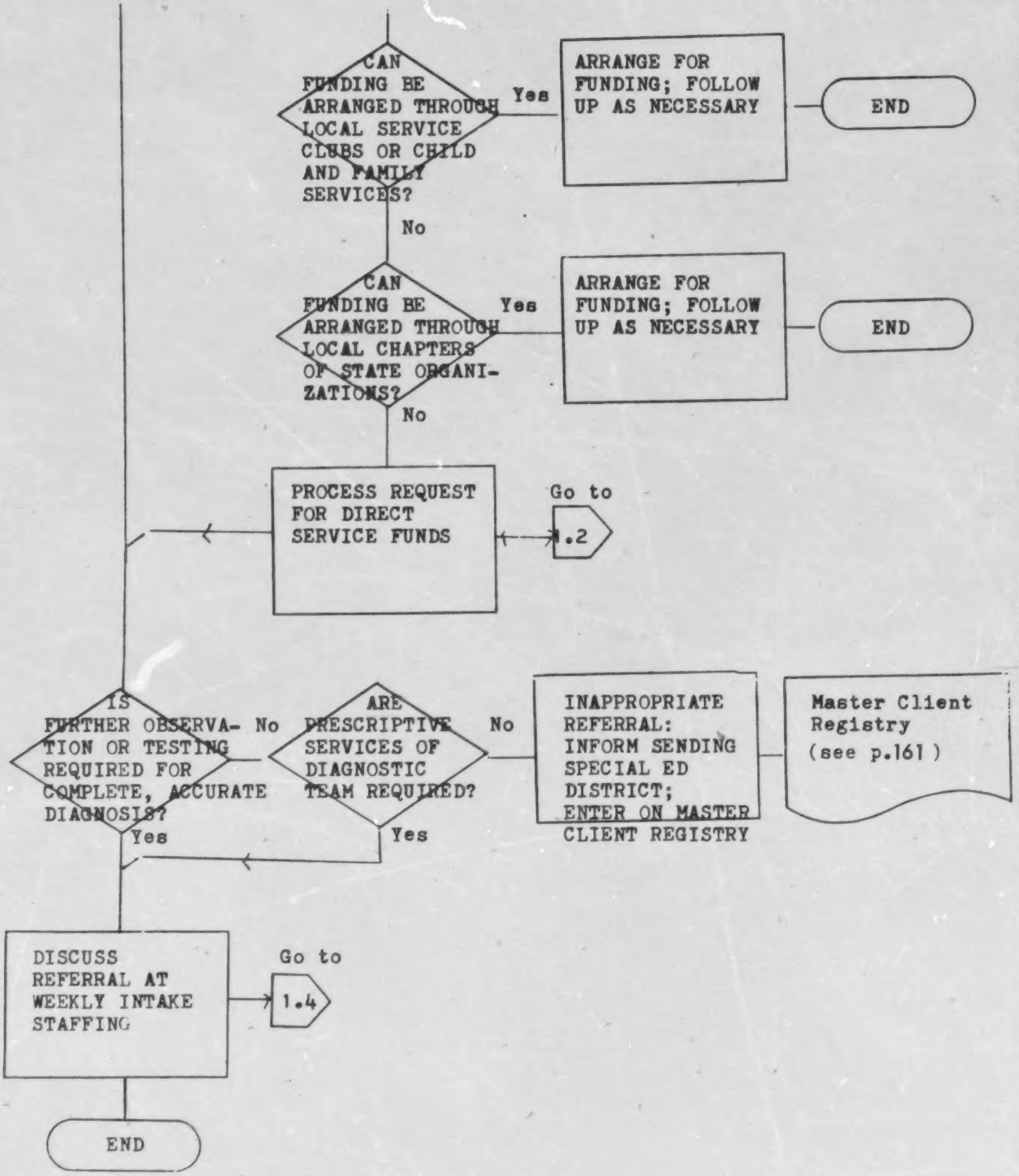
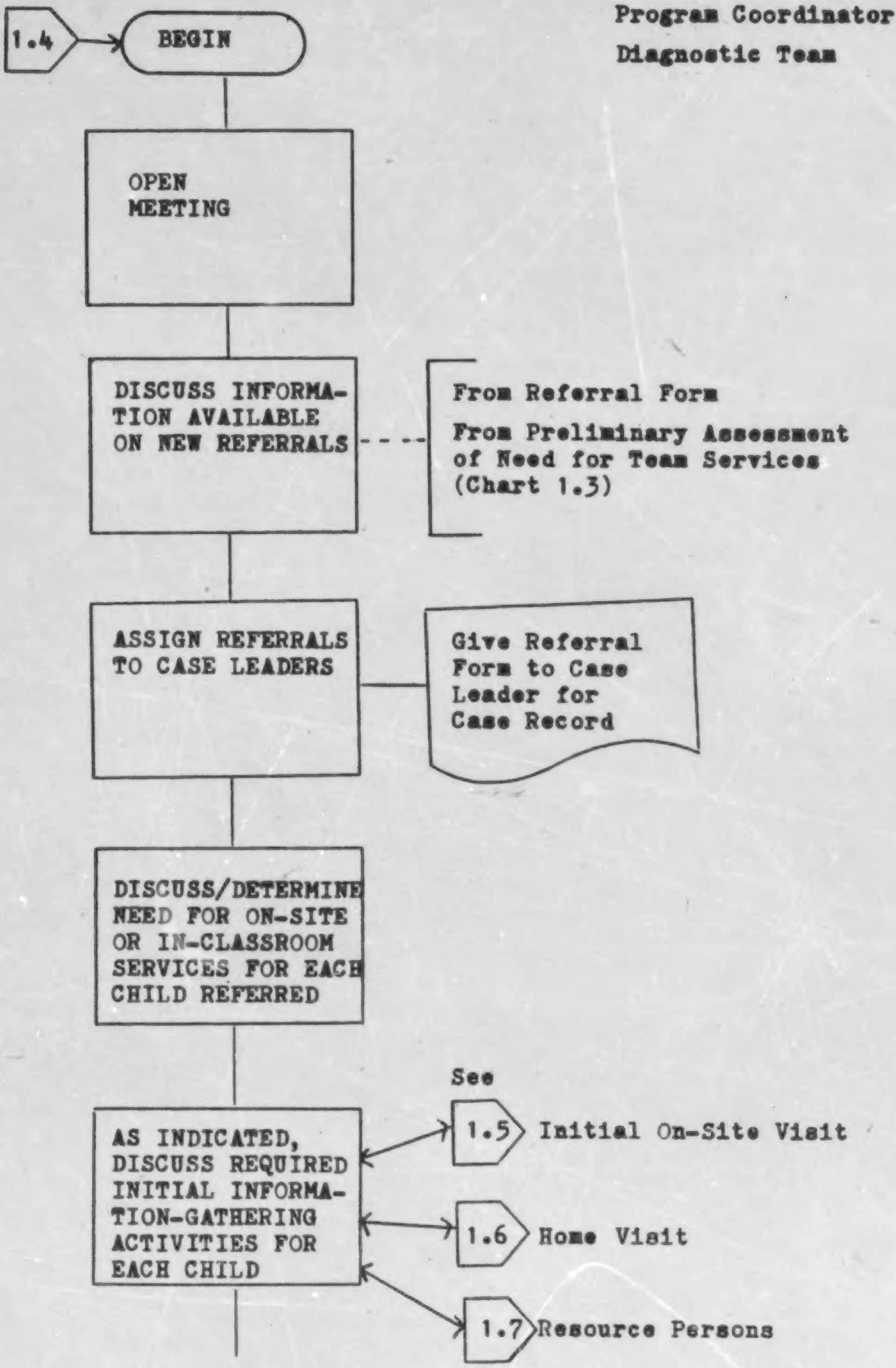

CAN FUNDING BE ARRANGED THROUGH LOCAL SERVICE CLUBS OR CHILD AND FAMILY SERVICES?
Yes
ARRANGE FOR FUNDING; FOLLOW UP AS NECESSARY
END
No
CAN FUNDING BE ARRANGED THROUGH LOCAL CHAPTERS OF STATE ORGANIZATIONS?
Yes
ARRANGE FOR FUNDING; FOLLOW UP AS NECESSARY
END
No
PROCESS REQUEST FOR DIRECT SERVICE FUNDS
Go to
1.2
IS FURTHER OBSERVATION OR TESTING REQUIRED FOR COMPLETE, ACCURATE DIAGNOSIS?
No
ARE PRESCRIPTIVE SERVICES OF DIAGNOSTIC TEAM REQUIRED?
No
INAPPROPRIATE REFERRAL: INFORM SENDING SPECIAL ED DISTRICT; ENTER ON MASTER CLIENT REGISTRY
Master Client Registry (see p.161)
Yes
Yes
DISCUSS REFERRAL AT WEEKLY INTAKE STAFFING
Go to
1.4
END

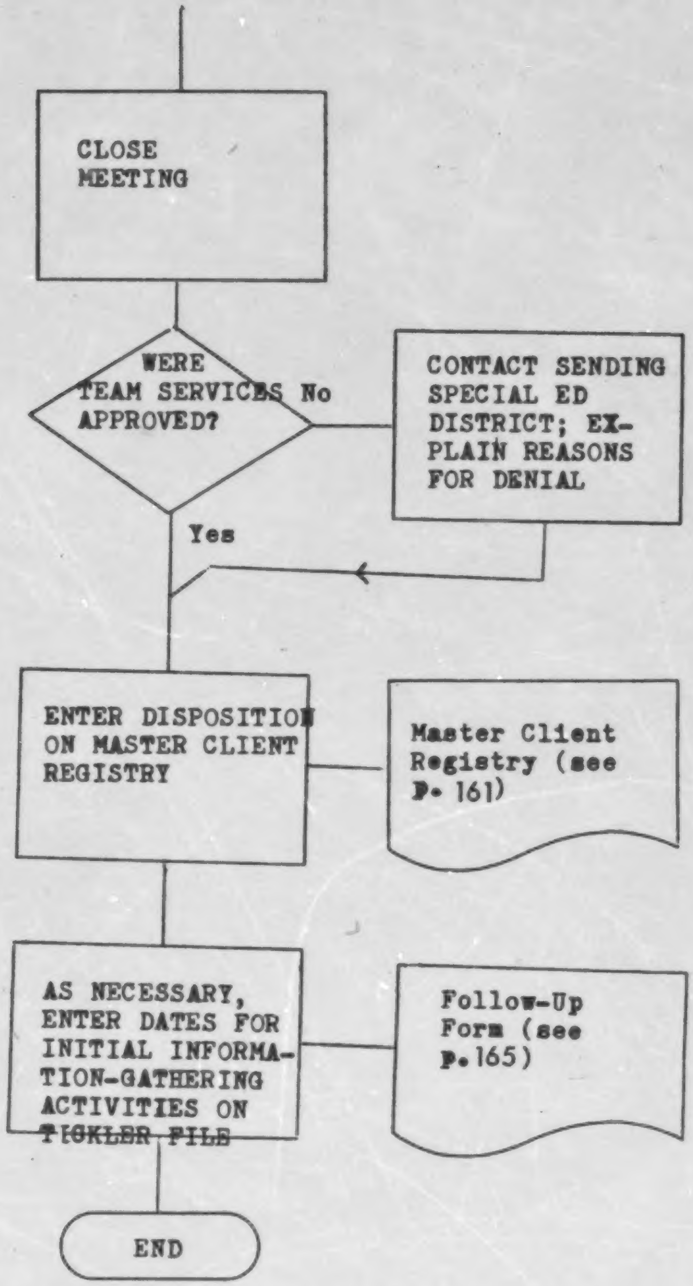
Chart 1.4 CONDUCT/PARTICIPATE IN WEEKLY INTAKE STAFFING

Program Coordinator
Diagnostic Team


1.4
BEGIN
OPEN MEETING
DISCUSS INFORMATION AVAILABLE ON NEW REFERRALS
From Referral Form
From Preliminary Assessment of Need for Team Services (Chart 1.3)
ASSIGN REFERRALS TO CASE LEADERS
Give Referral Form to Case Leader for Case Record
DISCUSS/DETERMINE NEED FOR ON-SITE OR IN-CLASSROOM SERVICES FOR EACH CHILD REFERRED
AS INDICATED, DISCUSS REQUIRED INITIAL INFORMATION-GATHERING ACTIVITIES FOR EACH CHILD
See
1.5 Initial On-Site Visit
1.6 Home Visit
1.7 Resource Persons

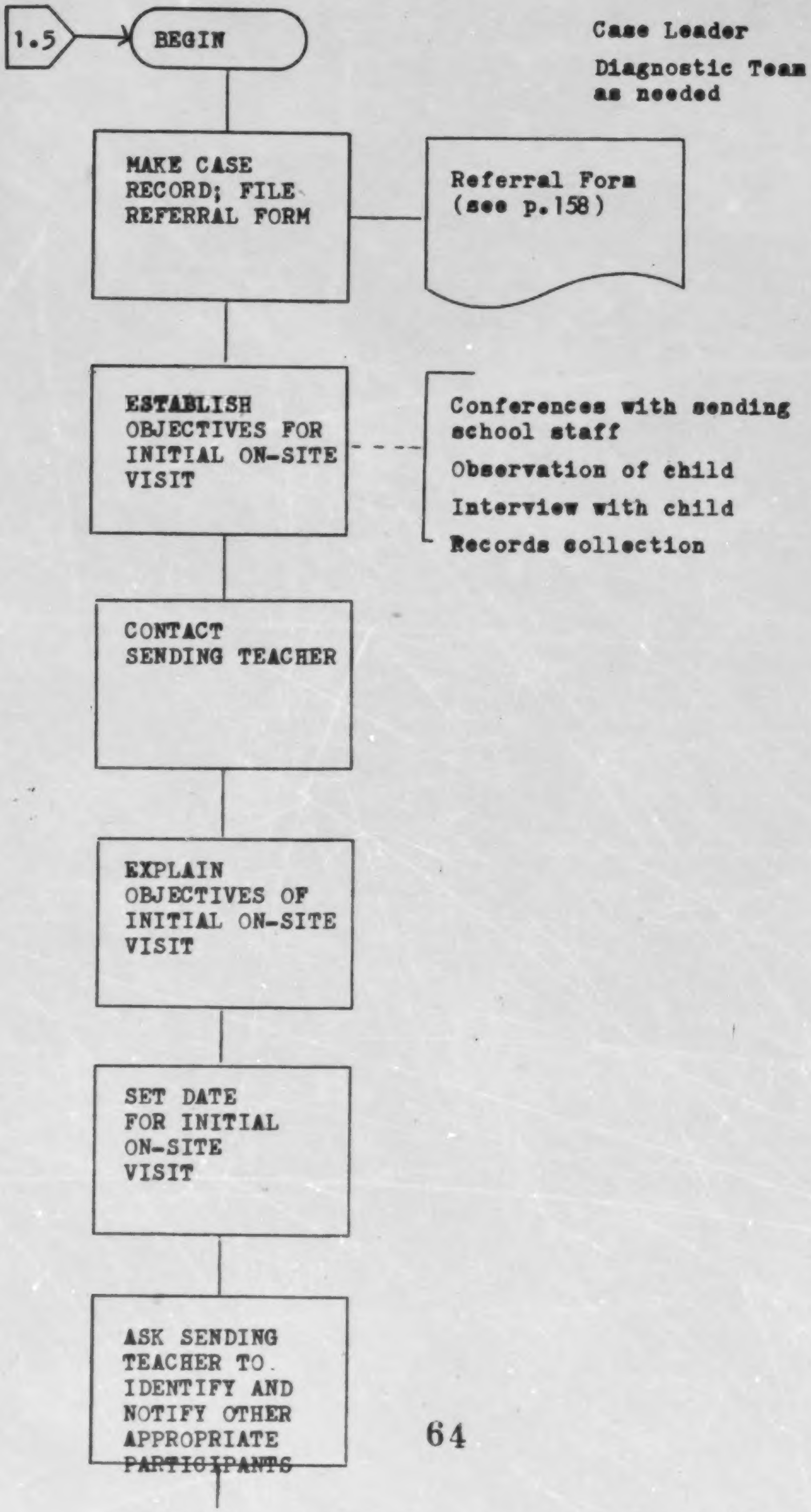
Continued on next page

Chart 1.4 Continued


CLOSE MEETING
WERE TEAM SERVICES APPROVED?
No
Yes
CONTACT SENDING SPECIAL ED DISTRICT; EXPLAIN REASONS FOR DENIAL
ENTER DISPOSITION ON MASTER CLIENT REGISTRY
Master Client Registry (see p. 161)
AS NECESSARY, ENTER DATES FOR INITIAL INFORMATION-GATHERING ACTIVITIES ON TICKLER FILE
Follow-Up Form (see p. 165)
END

Page two of two

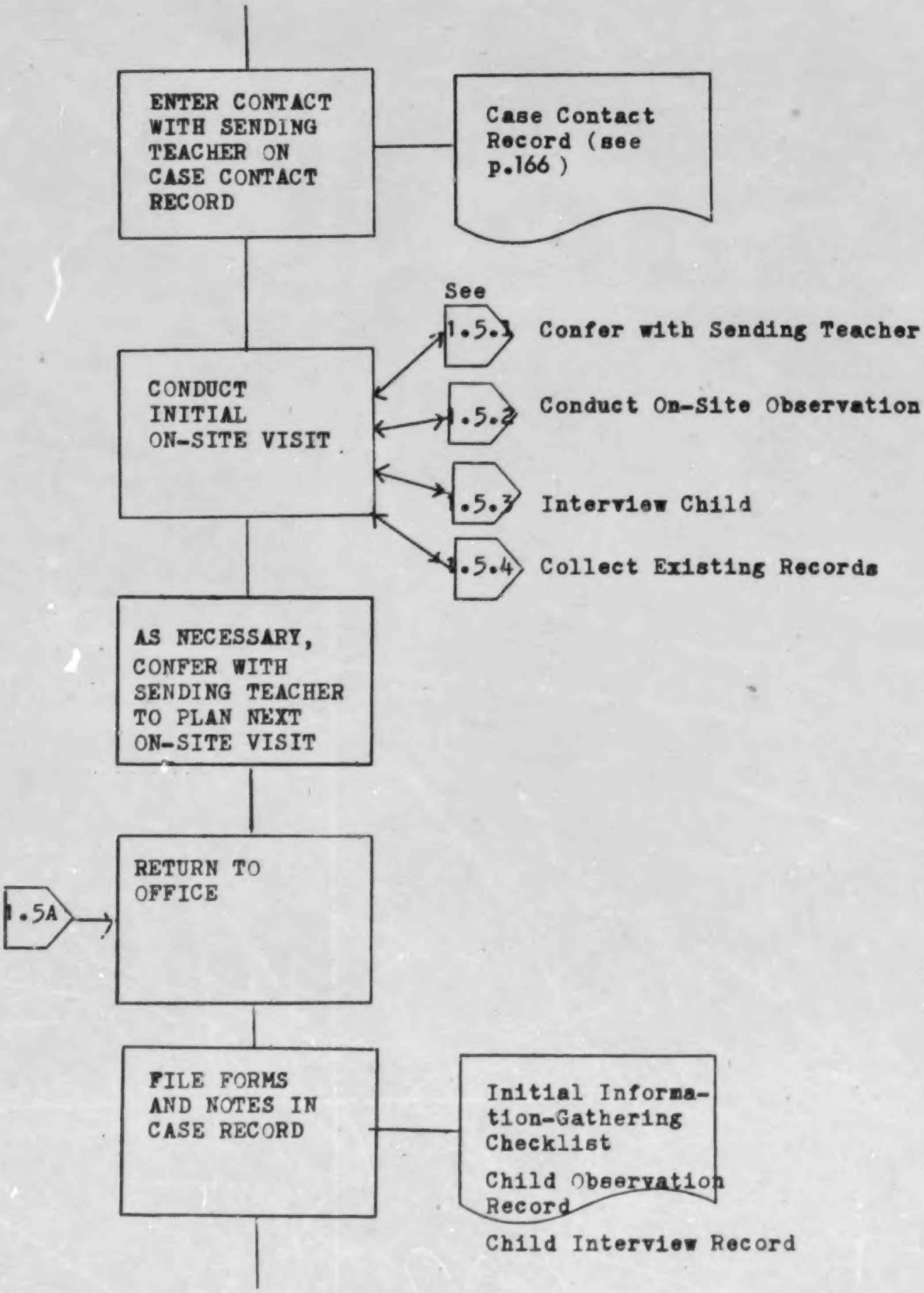
Chart 1.5 PLAN/CONDUCT INITIAL ON-SITE VISIT


1.5
BEGIN
Case Leader
Diagnostic Team as needed
MAKE CASE RECORD; FILE REFERRAL FORM
Referral Form (see p.158)
ESTABLISH OBJECTIVES FOR INITIAL ON-SITE VISIT
Conferences with sending school staff
Observation of child
Interview with child
Records collection
CONTACT SENDING TEACHER
EXPLAIN OBJECTIVES OF INITIAL ON-SITE VISIT
SET DATE FOR INITIAL ON-SITE VISIT
ASK SENDING TEACHER TO IDENTIFY AND NOTIFY OTHER APPROPRIATE PARTICIPANTS

Continued on next page

Page one of three

Chart 1.5 Continued


ENTER CONTACT WITH SENDING TEACHER ON CASE CONTACT RECORD
Case Contact Record (see p.166)
See
1.5.1
Confer with Sending Teacher
1.5.2
Conduct On-Site Observation
1.5.3
Interview Child
1.5.4
Collect Existing Records
CONDUCT INITIAL ON-SITE VISIT
AS NECESSARY, CONFER WITH SENDING TEACHER TO PLAN NEXT ON-SITE VISIT
1.5A
RETURN TO OFFICE
FILE FORMS AND NOTES IN CASE RECORD
Initial Information-Gathering Checklist
Child Observation Record
Child Interview Record

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Cnart 1.5 Continued

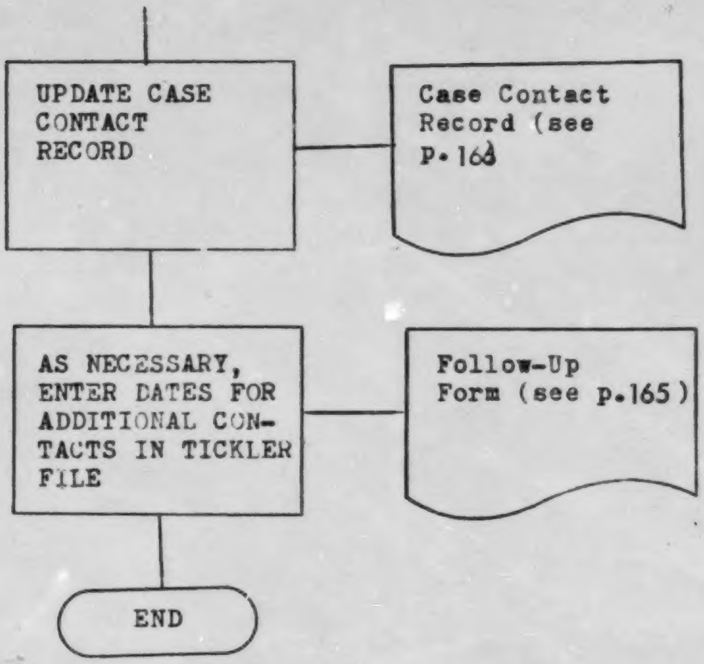

UPDATE CASE CONTACT RECORD
Case Contact Record (see p.163
AS NECESSARY, ENTER DATES FOR ADDITIONAL CONTACTS IN TICKLER FILE
Follow-Up Form (see p.165)
END

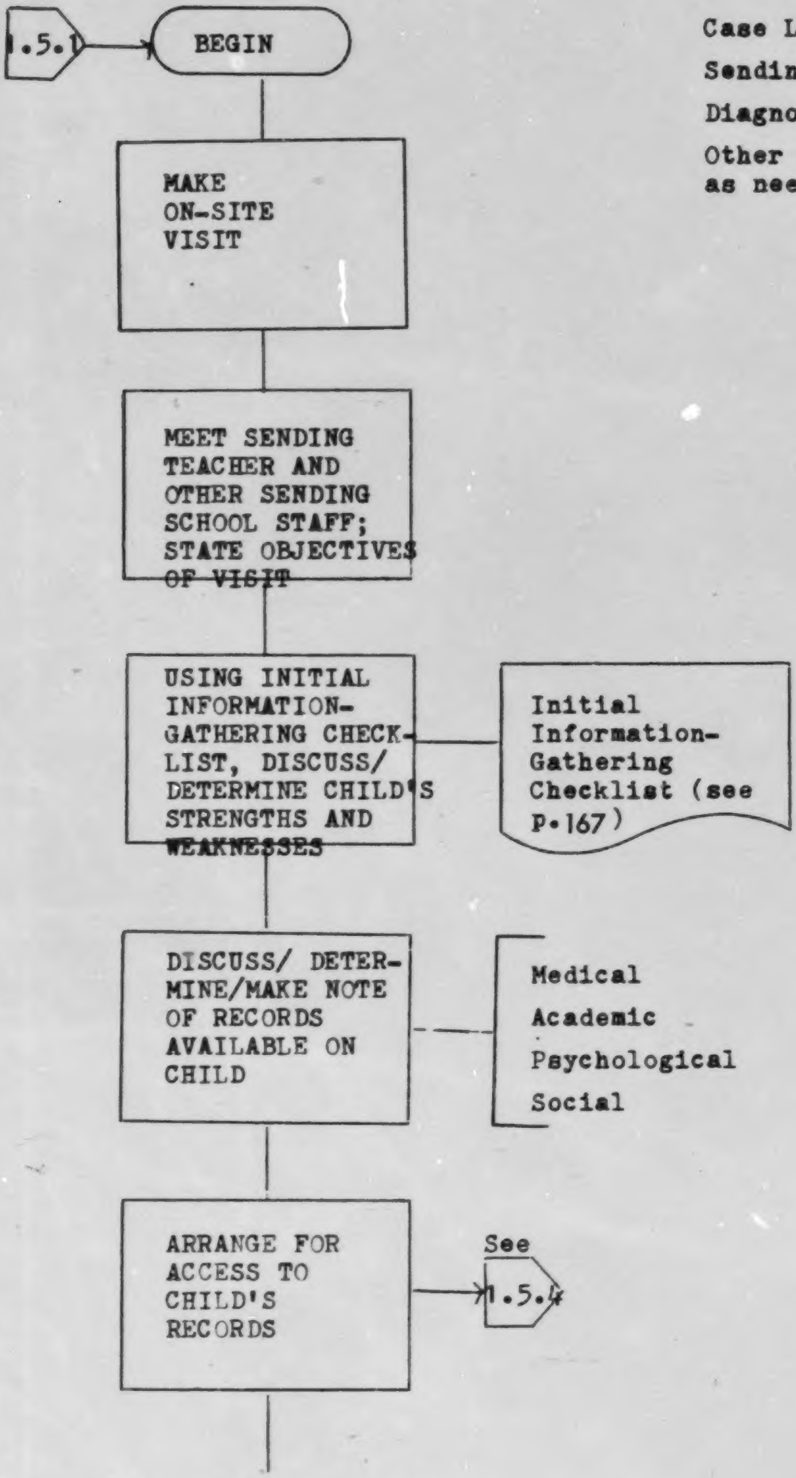
Chart 1.5.1 CONFER WITH SENDING TEACHER

Case Leader

Sending Teacher

Diagnostic Team as needed

Other Sending School Staff as needed


1.5.1
BEGIN
MAKE ON-SITE VISIT
MEET SENDING TEACHER AND OTHER SENDING SCHOOL STAFF; STATE OBJECTIVES OF VISIT
USING INITIAL INFORMATION-GATHERING CHECKLIST, DISCUSS/ DETERMINE CHILD'S STRENGTHS AND WEAKNESSES
Initial Information-Gathering Checklist (see p.167)
DISCUSS/ DETERMINE/MAKE NOTE OF RECORDS AVAILABLE ON CHILD
Medical
Academic
Psychological
Social
ARRANGE FOR ACCESS TO CHILD'S RECORDS
See
1.5.4

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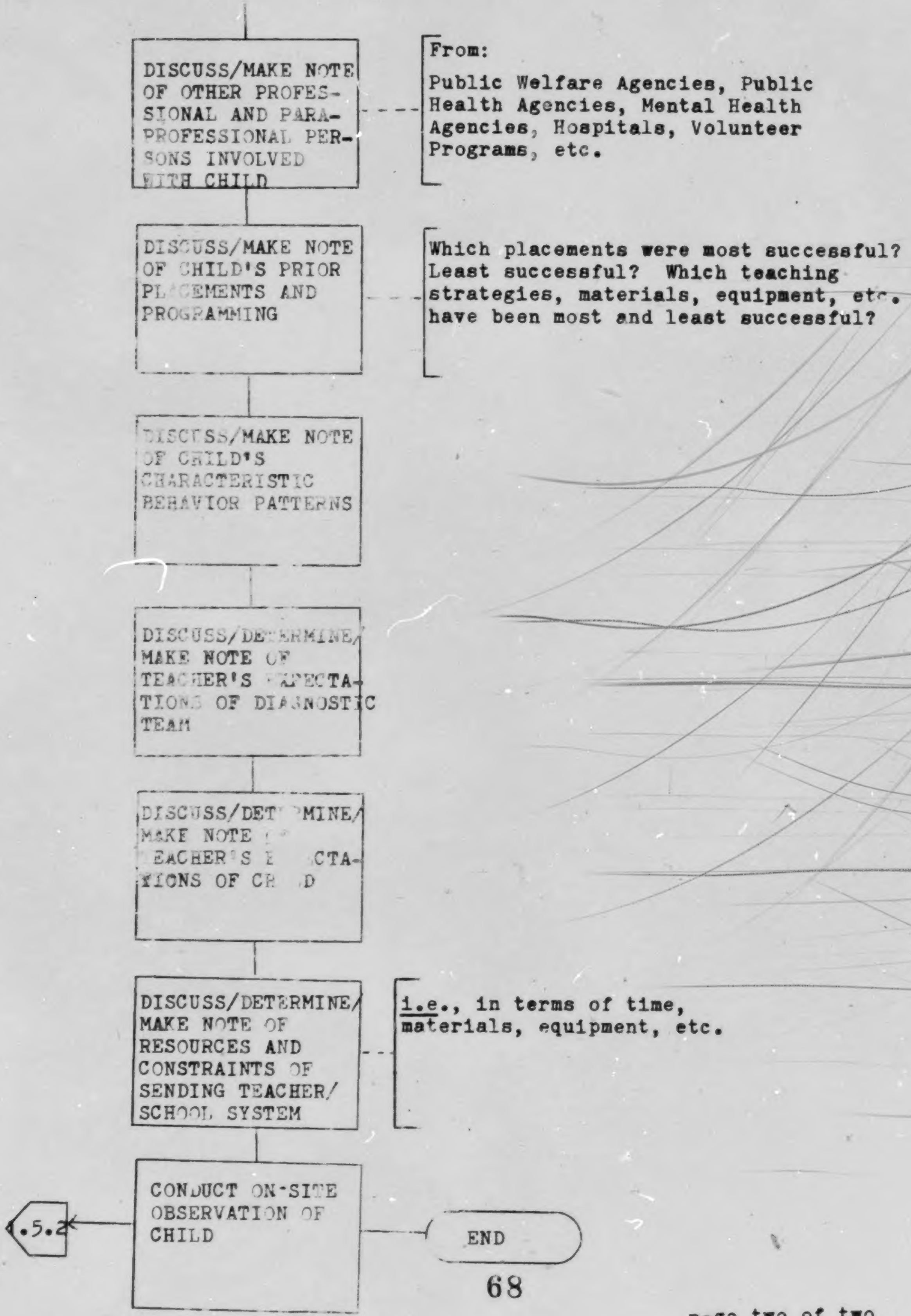
5.1 Continued


DISCUSS/MAKE NOTE OF OTHER PROFESSIONAL AND PARAPROFESSIONAL PERSONS INVOLVED WITH CHILD
DISCUSS/MAKE NOTE OF CHILD'S PRIOR PLACEMENTS AND PROGRAMMING
DISCUSS/MAKE NOTE OF CHILD'S CHARACTERISTIC BEHAVIOR PATTERNS
DISCUSS/DETERMINE/MAKE NOTE OF TEACHER'S EXPECTATIONS OF DIAGNOSTIC TEAM
DISCUSS/DETERMINE/MAKE NOTE OF TEACHER'S EXPECTATIONS OF CHILD
DISCUSS/DETERMINE/MAKE NOTE OF RESOURCES AND CONSTRAINTS OF SENDING TEACHER/SCHOOL SYSTEM
CONDUCT ON-SITE OBSERVATION OF CHILD
1.5.2
END

From:

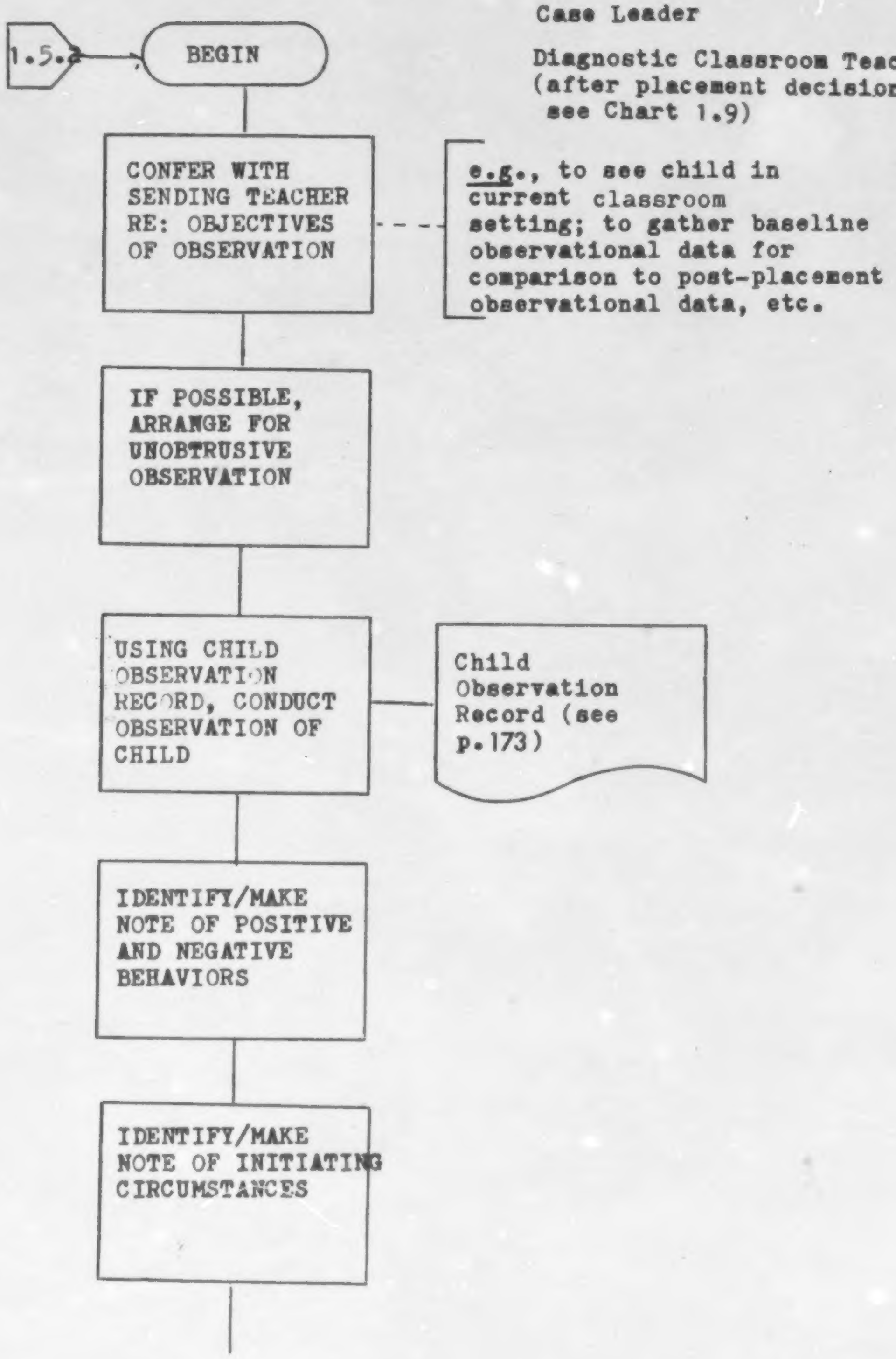
Public Welfare Agencies, Public Health Agencies, Mental Health Agencies, Hospitals, Volunteer Programs, etc.

Which placements were most successful? Least successful? Which teaching strategies, materials, equipment, etc. have been most and least successful?

i.e., in terms of time, materials, equipment, etc.

page two of two

Chart 1.5.2 CONDUCT ON-SITE OBSERVATION


1.5.2
BEGIN
CONFER WITH SENDING TEACHER RE: OBJECTIVES OF OBSERVATION
e.g., to see child in current classroom setting; to gather baseline observational data for comparison to post-placement observational data, etc.
IF POSSIBLE, ARRANGE FOR UNOBTRUSIVE OBSERVATION
USING CHILD OBSERVATION RECORD, CONDUCT OBSERVATION OF CHILD
Child Observation Record (see p.173)
IDENTIFY/MAKE NOTE OF POSITIVE AND NEGATIVE BEHAVIORS
IDENTIFY/MAKE NOTE OF INITIATING CIRCUMSTANCES

Case Leader

Diagnostic Classroom Teacher
(after placement decision--
see Chart 1.9)

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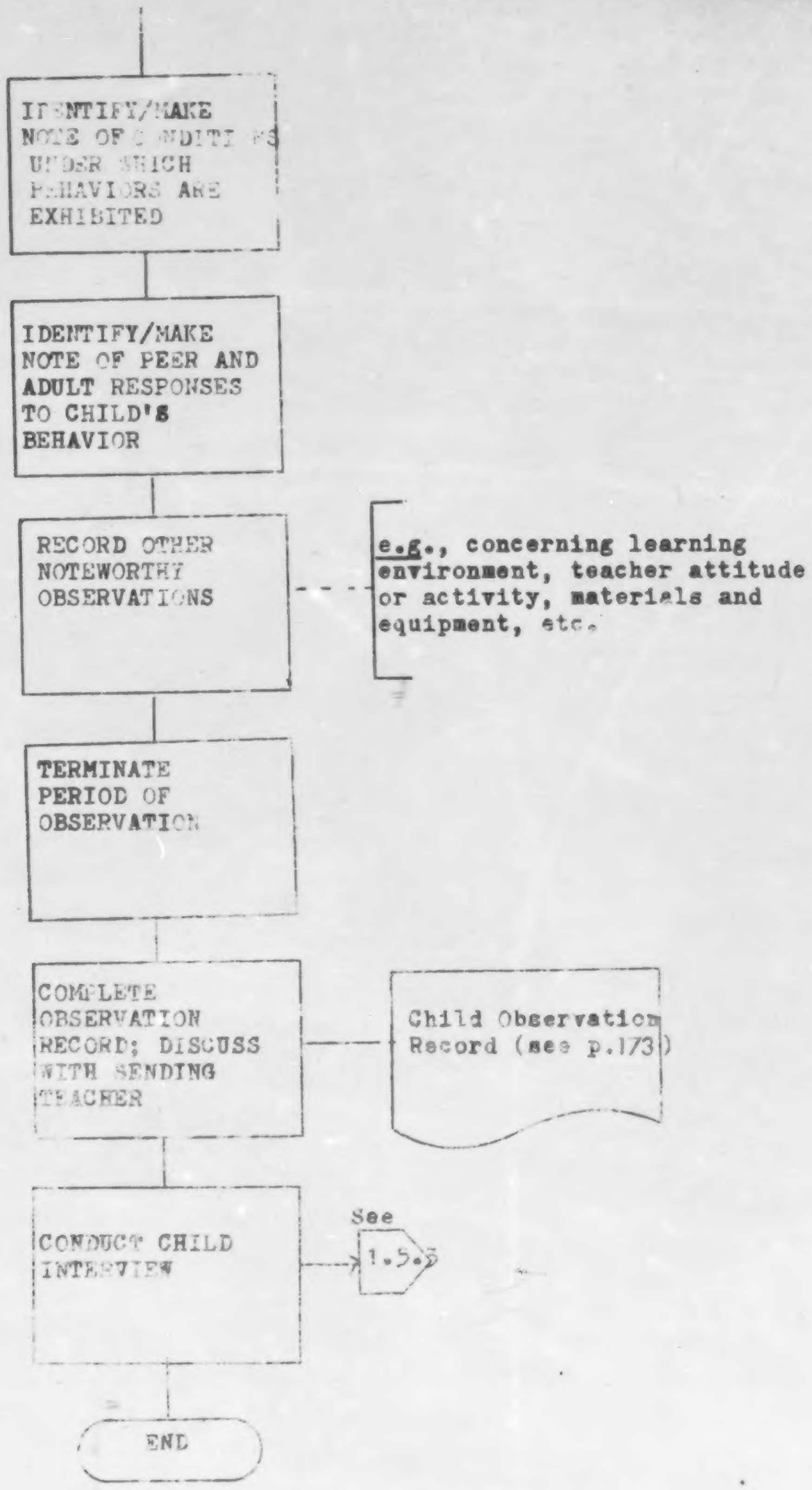
IDENTIFY/MAKE NOTE OF CONDITIONS UNDER WHICH BEHAVIORS ARE EXHIBITED
IDENTIFY/MAKE NOTE OF PEER AND ADULT RESPONSES TO CHILD'S BEHAVIOR
RECORD OTHER NOTEWORTHY OBSERVATIONS
e.g., concerning learning environment, teacher attitude or activity, materials and equipment, etc.
TERMINATE PERIOD OF OBSERVATION
COMPLETE OBSERVATION RECORD; DISCUSS WITH SENDING TEACHER
Child Observation Record (see p.173)
CONDUCT CHILD INTERVIEW
See
1.5.3
END

Chart 1.5.3 INTERVIEW CHILD

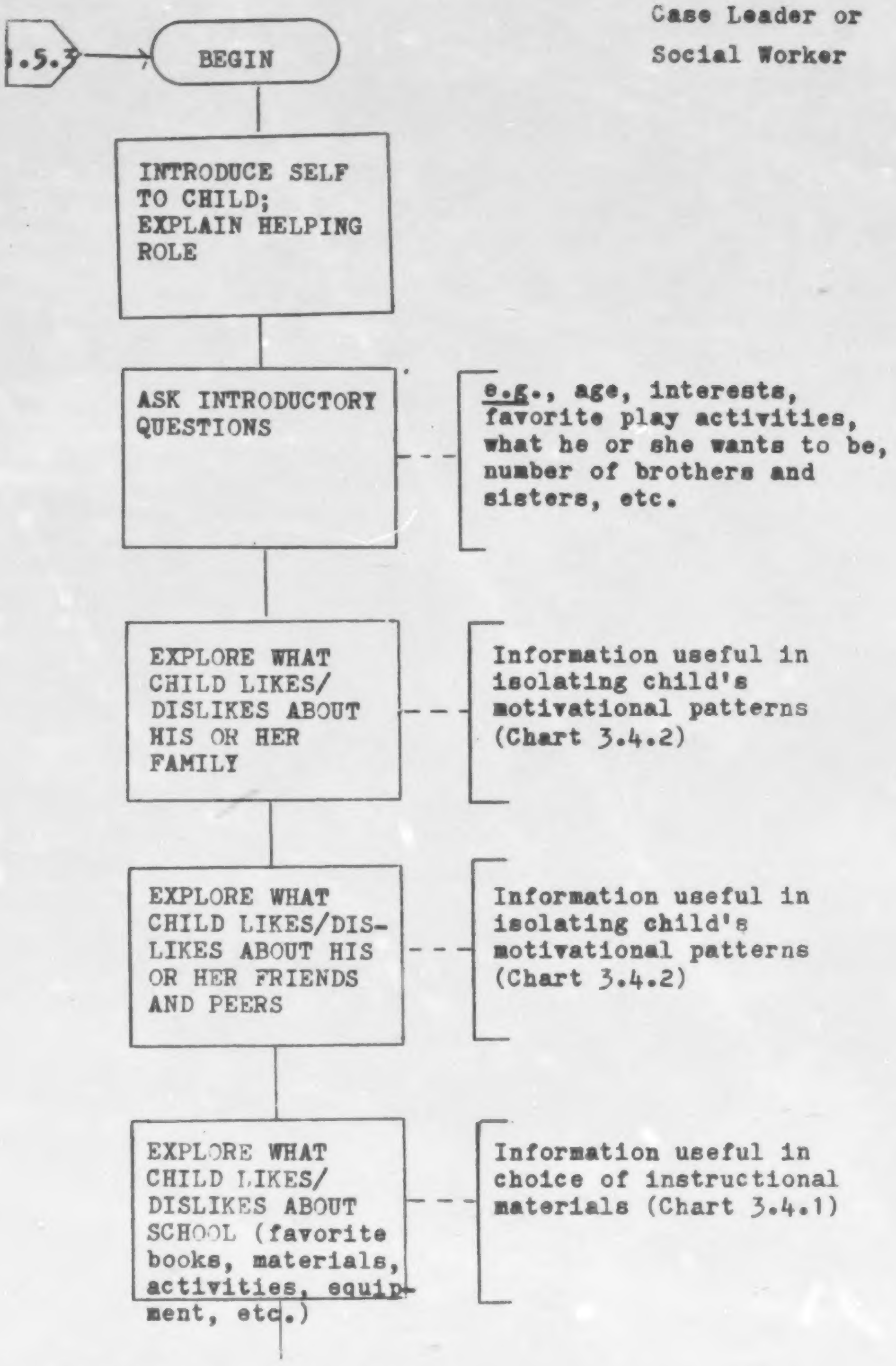
Case Leader or Social Worker
.5.3
BEGIN
INTRODUCE SELF TO CHILD; EXPLAIN HELPING ROLE
ASK INTRODUCTORY QUESTIONS
e.g., age, interests, favorite play activities, what he or she wants to be, number of brothers and sisters, etc.
EXPLORE WHAT CHILD LIKES/DISLIKES ABOUT HIS OR HER FAMILY
Information useful in isolating child's motivational patterns (Chart 3.4.2)
EXPLORE WHAT CHILD LIKES/DISLIKES ABOUT HIS OR HER FRIENDS AND PEERS
Information useful in isolating child's motivational patterns (Chart 3.4.2)
EXPLORE WHAT CHILD LIKES/DISLIKES ABOUT SCHOOL (favorite books, materials, activities, equipment, etc.)
Information useful in choice of instructional materials (Chart 3.4.1)

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Chart 1.5.3 Continued

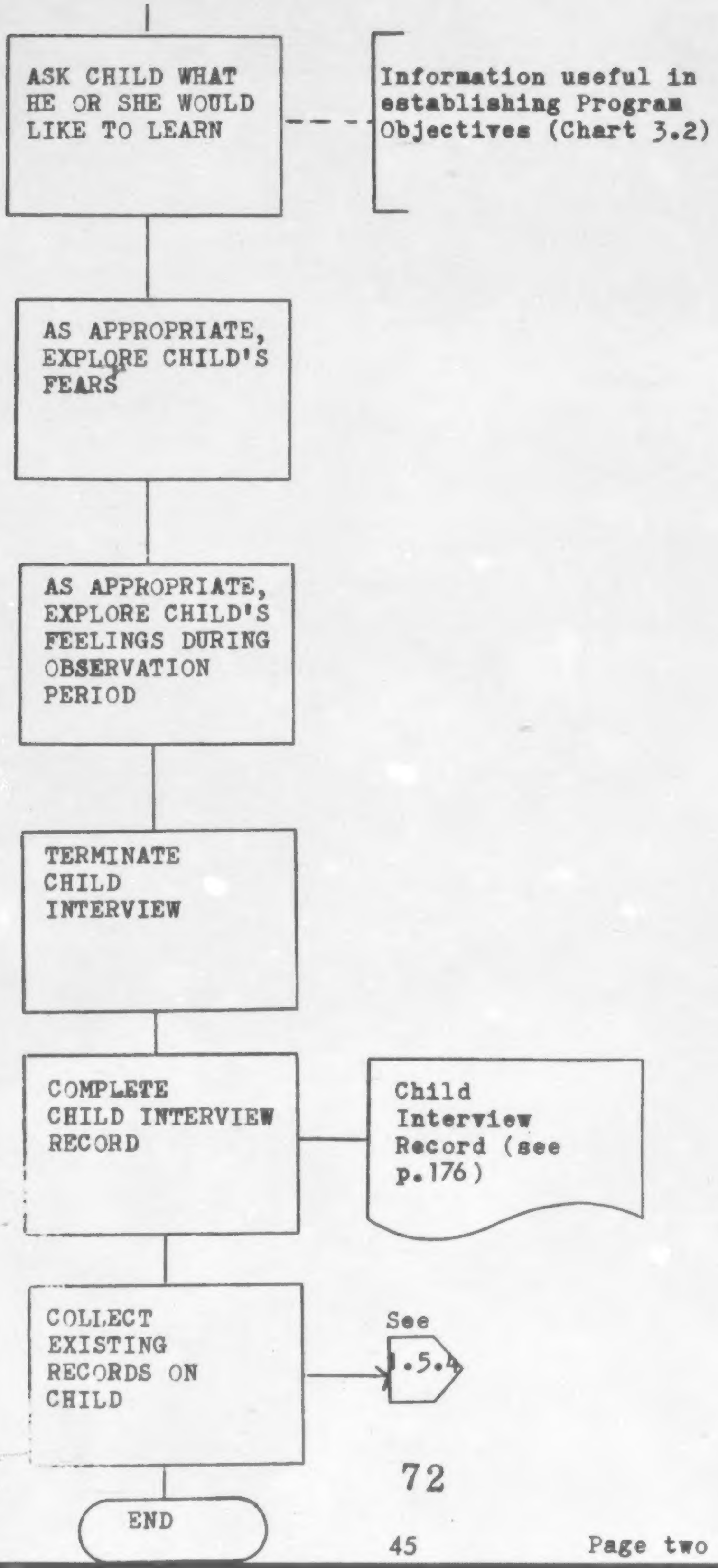
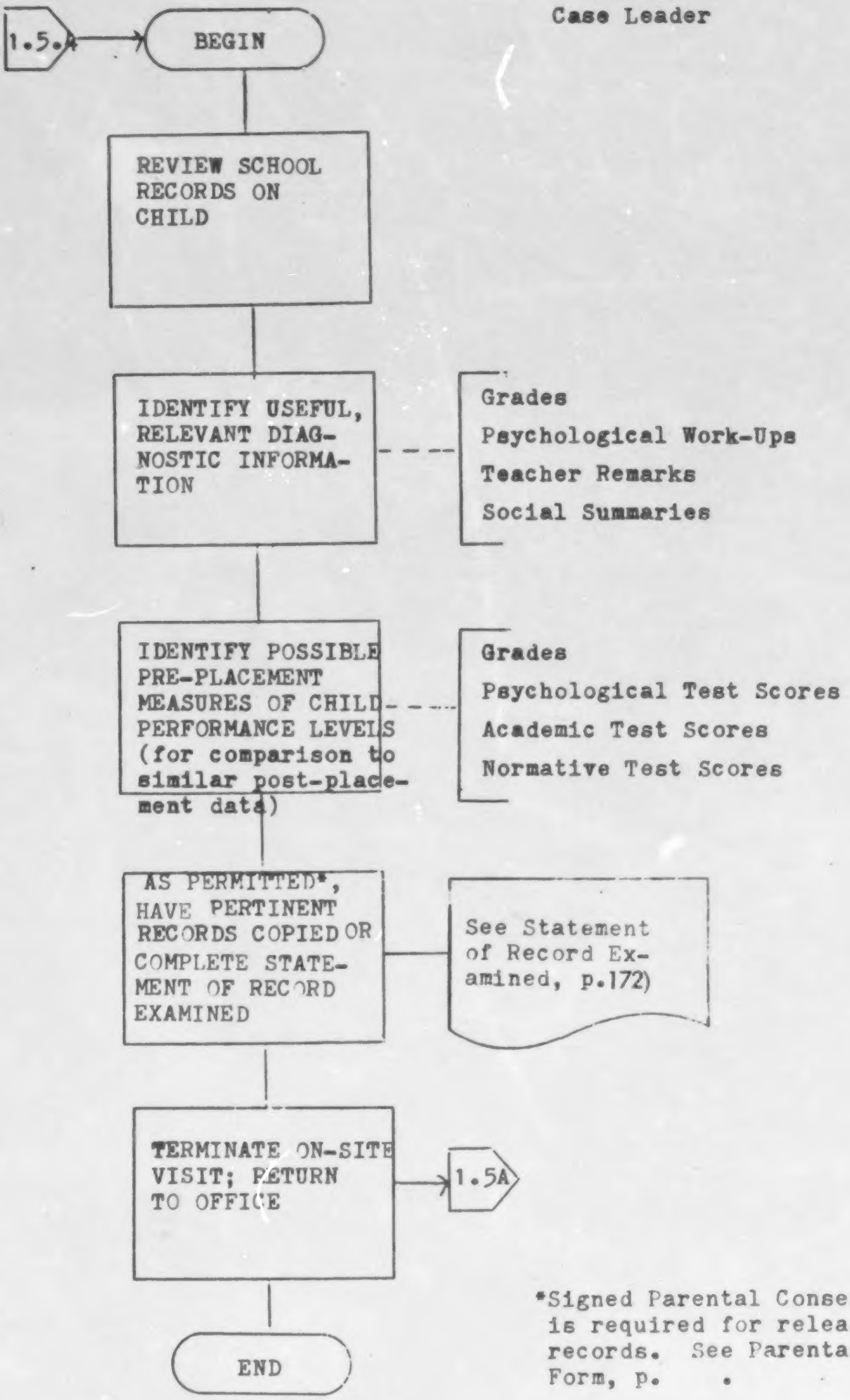
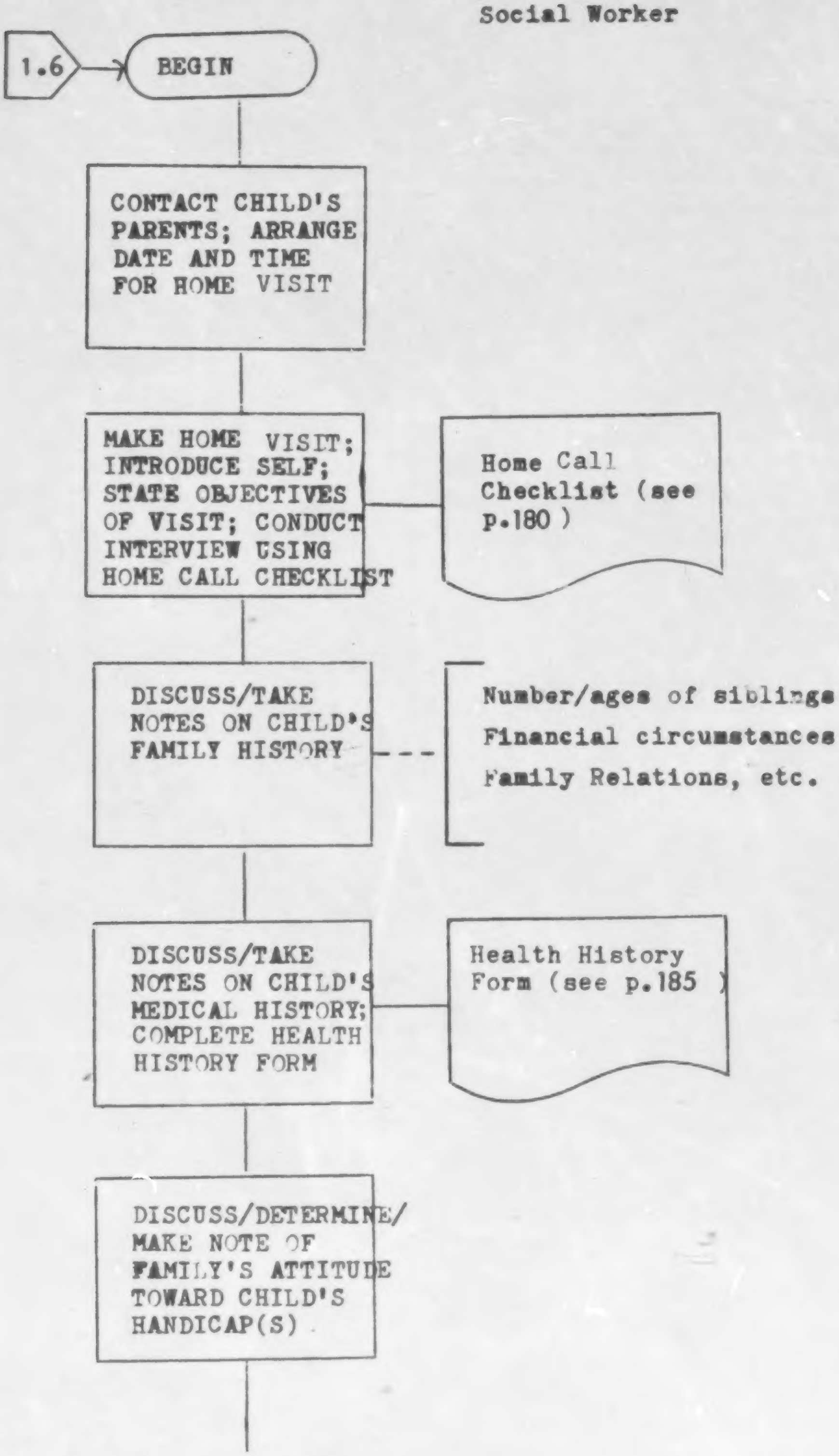

ASK CHILD WHAT HE OR SHE WOULD LIKE TO LEARN
Information useful in establishing Program Objectives (Chart 3.2)
AS APPROPRIATE, EXPLORE CHILD'S FEARS
AS APPROPRIATE, EXPLORE CHILD'S FEELINGS DURING OBSERVATION PERIOD
TERMINATE CHILD INTERVIEW
COMPLETE CHILD INTERVIEW RECORD
Child Interview Record (see p.176)
COLLECT EXISTING RECORDS ON CHILD
See
1.5.4
END

Chart 1.5.4 COLLECT EXISTING RECORDS


Case Leader
1.5.A
BEGIN
REVIEW SCHOOL RECORDS ON CHILD
IDENTIFY USEFUL, RELEVANT DIAGNOSTIC INFORMATION
Grades
Psychological Work-Ups
Teacher Remarks
Social Summaries
IDENTIFY POSSIBLE PRE-PLACEMENT MEASURES OF CHILD PERFORMANCE LEVELS (for comparison to similar post-placement data)
Grades
Psychological Test Scores
Academic Test Scores
Normative Test Scores
AS PERMITTED*, HAVE PERTINENT RECORDS COPIED OR COMPLETE STATEMENT OF RECORD EXAMINED
See Statement of Record Examined, p.172)
TERMINATE ON-SITE VISIT; RETURN TO OFFICE
1.5A
END

*Signed Parental Consent Form is required for release of records. See Parental Consent Form, p. .

Chart 1.6 MAKE HOME VISIT


Social Worker
1.6
BEGIN
CONTACT CHILD'S PARENTS; ARRANGE DATE AND TIME FOR HOME VISIT
MAKE HOME VISIT; INTRODUCE SELF; STATE OBJECTIVES OF VISIT; CONDUCT INTERVIEW USING HOME CALL CHECKLIST
Home Call Checklist (see p.180)
DISCUSS/TAKE NOTES ON CHILD'S FAMILY HISTORY
Number/ages of siblings
Financial circumstances
Family Relations, etc.
DISCUSS/TAKE NOTES ON CHILD'S MEDICAL HISTORY; COMPLETE HEALTH HISTORY FORM
Health History Form (see p.185)
DISCUSS/DETERMINE/ MAKE NOTE OF FAMILY'S ATTITUDE TOWARD CHILD'S HANDICAP(S)

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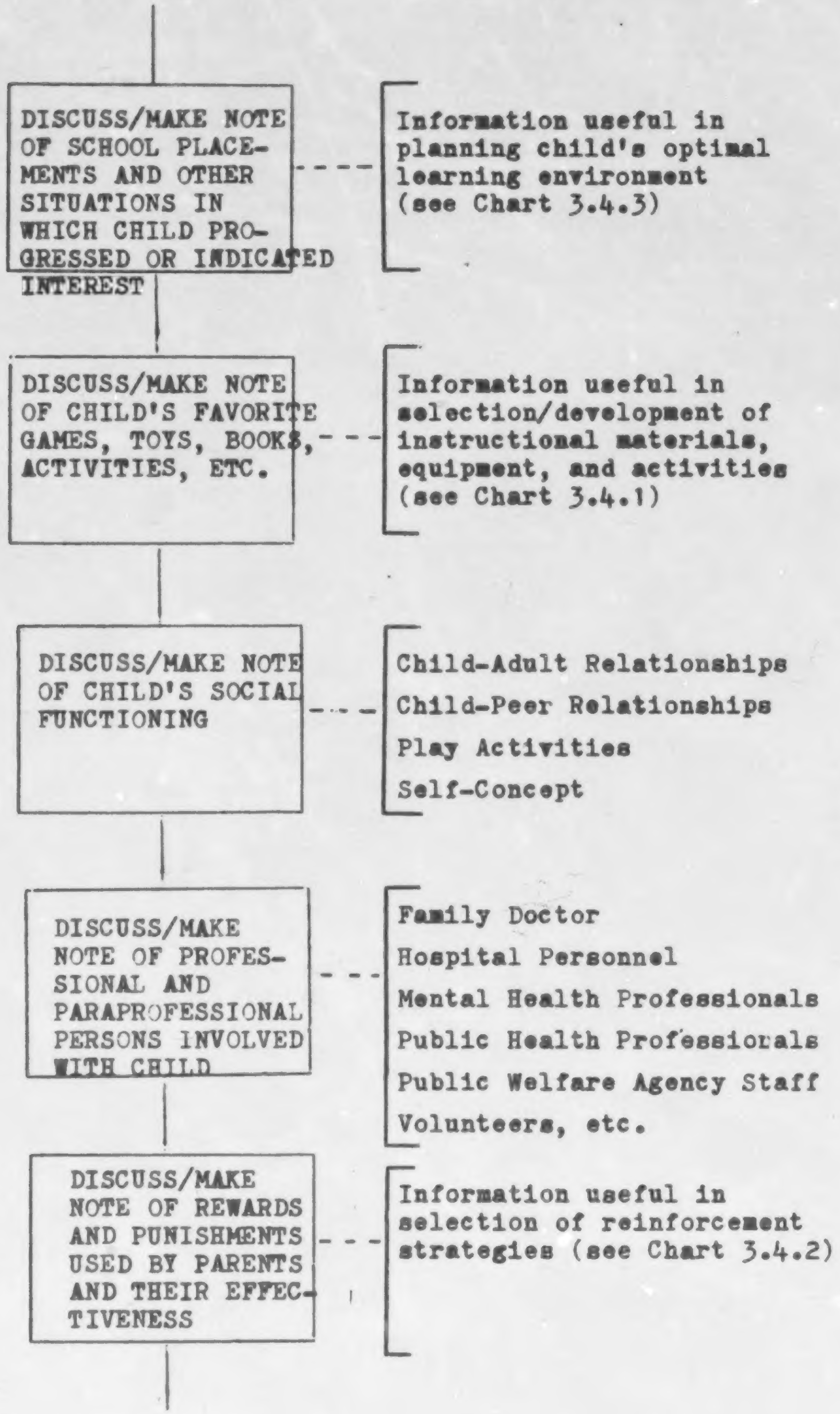
Page one of four

Chart 1.6 Continued



DISCUSS/MAKE NOTE OF SCHOOL PLACEMENTS AND OTHER SITUATIONS IN WHICH CHILD PROGRESSED OR INDICATED INTEREST

Information useful in planning child's optimal learning environment (see Chart 3.4.3)

DISCUSS/MAKE NOTE OF CHILD'S FAVORITE GAMES, TOYS, BOOKS, ACTIVITIES, ETC.

Information useful in selection/development of instructional materials, equipment, and activities (see Chart 3.4.1)

DISCUSS/MAKE NOTE OF CHILD'S SOCIAL FUNCTIONING

Child-Adult Relationships
Child-Peer Relationships
Play Activities
Self-Concept

DISCUSS/MAKE NOTE OF PROFESSIONAL AND PARAPROFESSIONAL PERSONS INVOLVED WITH CHILD

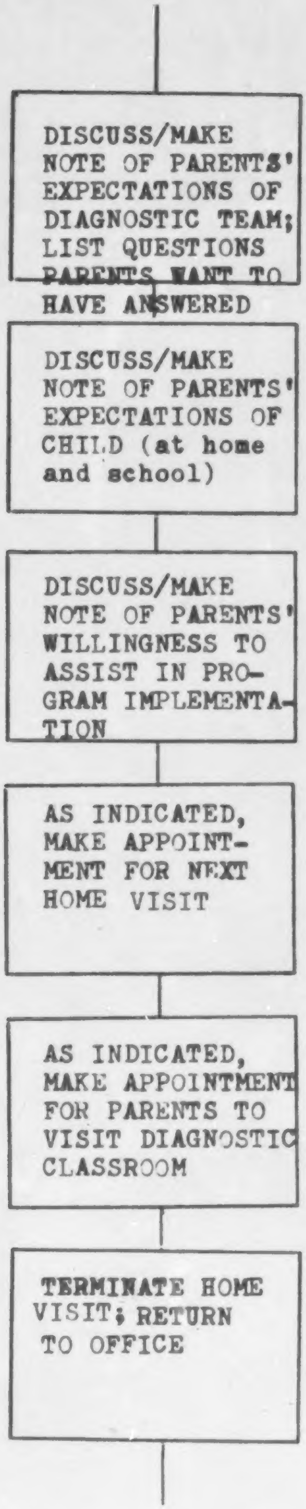
Family Doctor
Hospital Personnel
Mental Health Professionals
Public Health Professionals
Public Welfare Agency Staff
Volunteers, etc.

DISCUSS/MAKE NOTE OF REWARDS AND PUNISHMENTS USED BY PARENTS AND THEIR EFFECTIVENESS

Information useful in selection of reinforcement strategies (see Chart 3.4.2)

Continued on next page

Chart 1.6 Continued


DISCUSS/MAKE NOTE OF PARENTS' EXPECTATIONS OF DIAGNOSTIC TEAM; LIST QUESTIONS PARENTS WANT TO HAVE ANSWERED
DISCUSS/MAKE NOTE OF PARENTS' EXPECTATIONS OF CHILD (at home and school)
DISCUSS/MAKE NOTE OF PARENTS' WILLINGNESS TO ASSIST IN PROGRAM IMPLEMENTATION
AS INDICATED, MAKE APPOINTMENT FOR NEXT HOME VISIT
AS INDICATED, MAKE APPOINTMENT FOR PARENTS TO VISIT DIAGNOSTIC CLASSROOM
TERMINATE HOME VISIT; RETURN TO OFFICE

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Page three of four

Chart 1.6 Continued

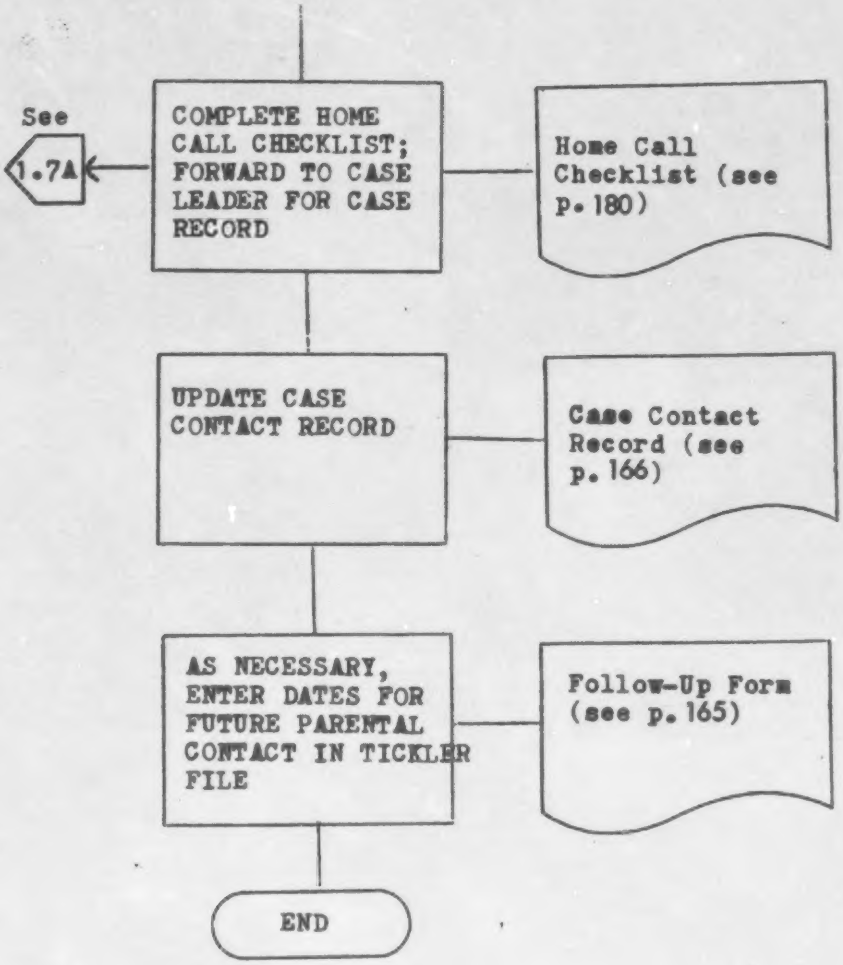
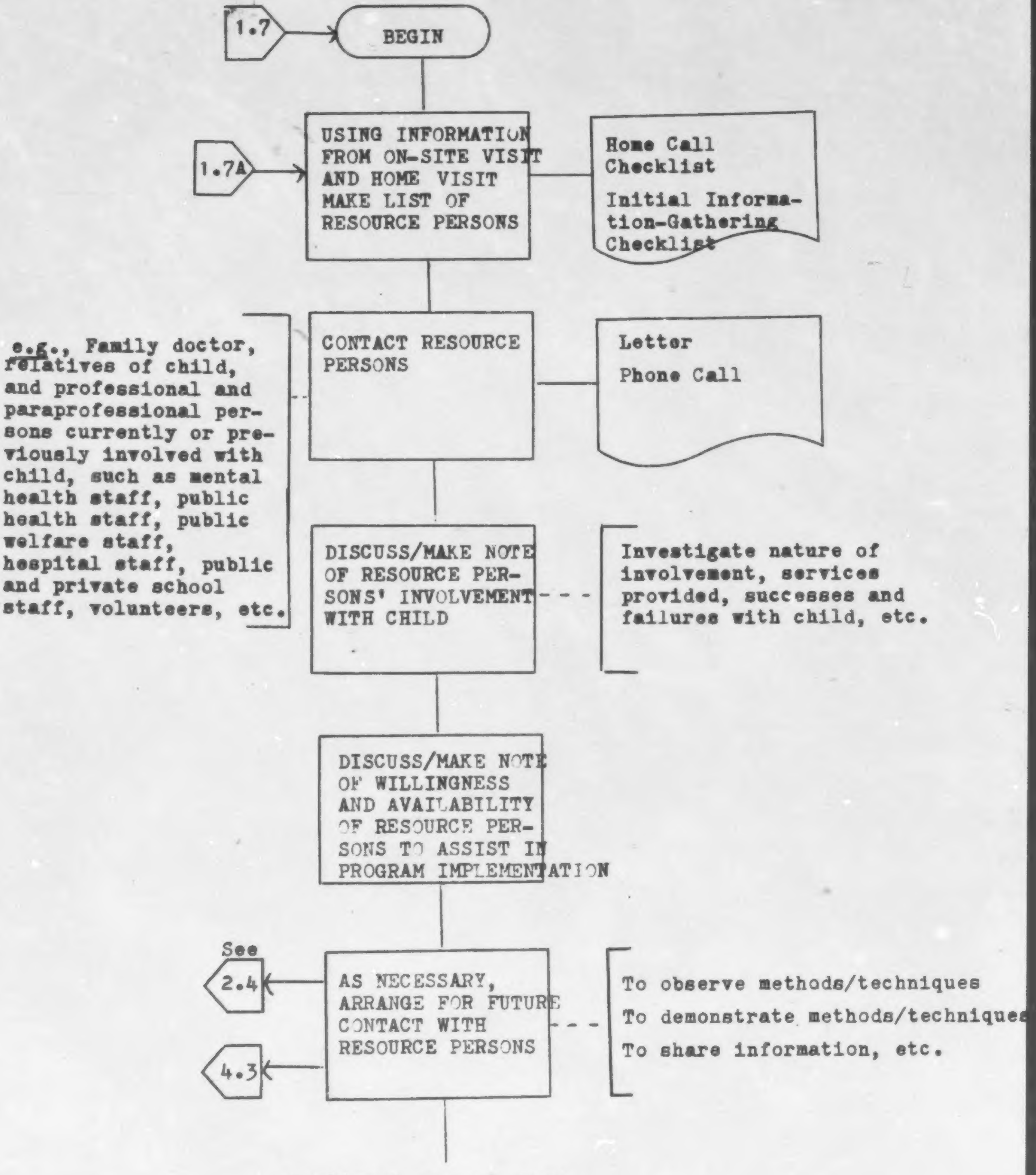

See
1.7A
COMPLETE HOME CALL CHECKLIST; FORWARD TO CASE LEADER FOR CASE RECORD
Home Call Checklist (see p. 180)
UPDATE CASE CONTACT RECORD
Case Contact Record (see p. 166)
AS NECESSARY, ENTER DATES FOR FUTURE PARENTAL CONTACT IN TICKLER FILE
Follow-Up Form (see p. 165)
END

Chart 1.7 CONTACT RESOURCE PERSONS


1.7
BEGIN
1.7A
USING INFORMATION FROM ON-SITE VISIT AND HOME VISIT MAKE LIST OF RESOURCE PERSONS
Home Call Checklist
Initial Information-Gathering Checklist
e.g., Family doctor, relatives of child, and professional and paraprofessional persons currently or previously involved with child, such as mental health staff, public health staff, public welfare staff, hospital staff, public and private school staff, volunteers, etc.
CONTACT RESOURCE PERSONS
Letter
Phone Call
DISCUSS/MAKE NOTE OF RESOURCE PERSONS' INVOLVEMENT WITH CHILD
Investigate nature of involvement, services provided, successes and failures with child, etc.
DISCUSS/MAKE NOTE OF WILLINGNESS AND AVAILABILITY OF RESOURCE PERSONS TO ASSIST IN PROGRAM IMPLEMENTATION
See
2.4
4.3
AS NECESSARY, ARRANGE FOR FUTURE CONTACT WITH RESOURCE PERSONS
To observe methods/techniques
To demonstrate methods/techniques
To share information, etc.

Continued on next page

Chart 1.7 Continued

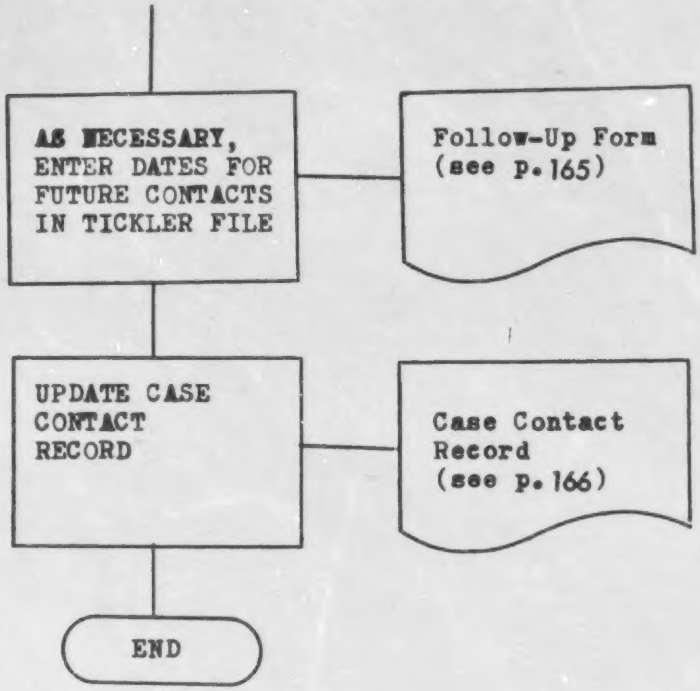

AS NECESSARY, ENTER DATES FOR FUTURE CONTACTS IN TICKLER FILE
Follow-Up Form (see p. 165)
UPDATE CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

Chart 1.8 REVIEW INFORMATION GATHERED; DECIDE ON NEED FOR CONTINUED SERVICES

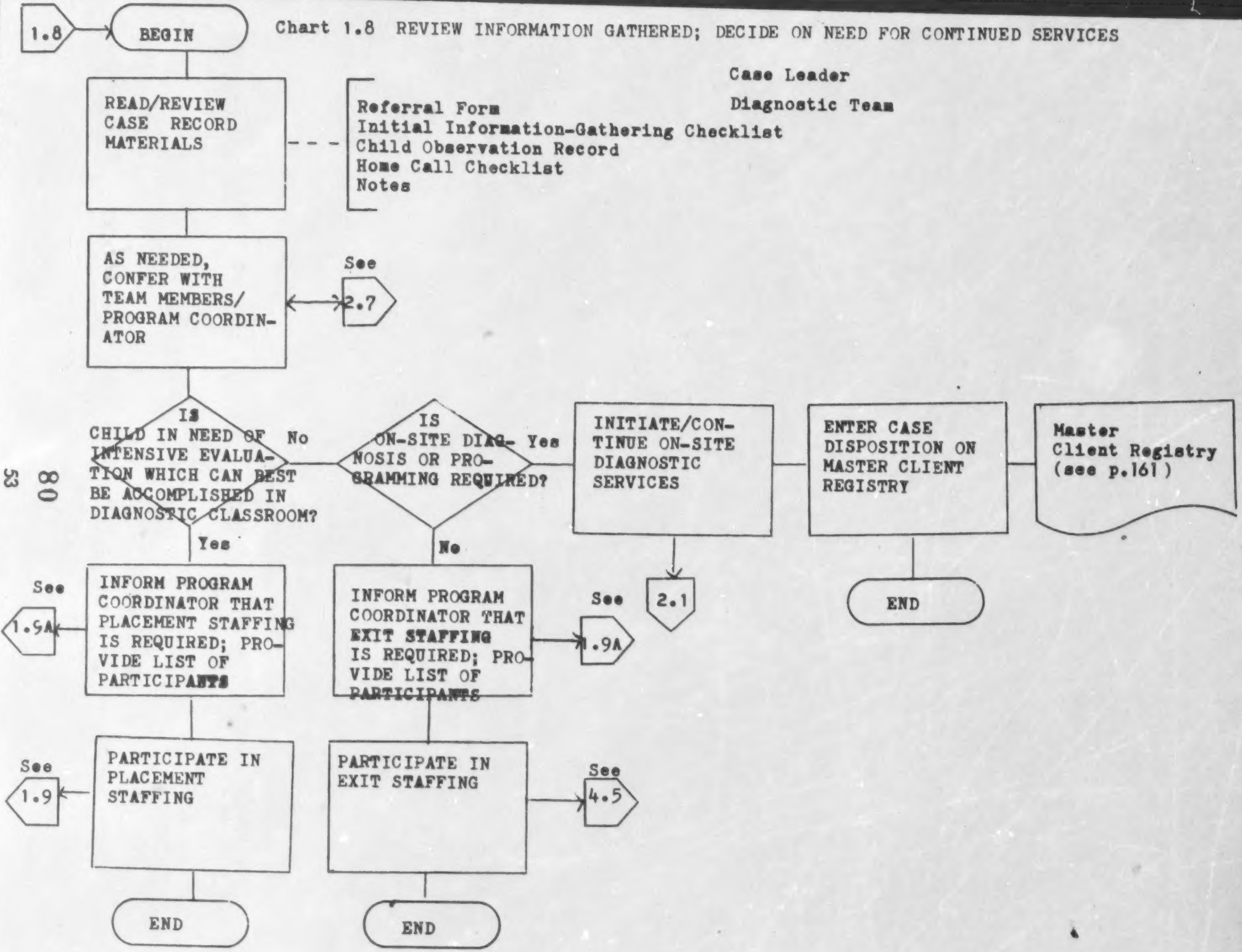
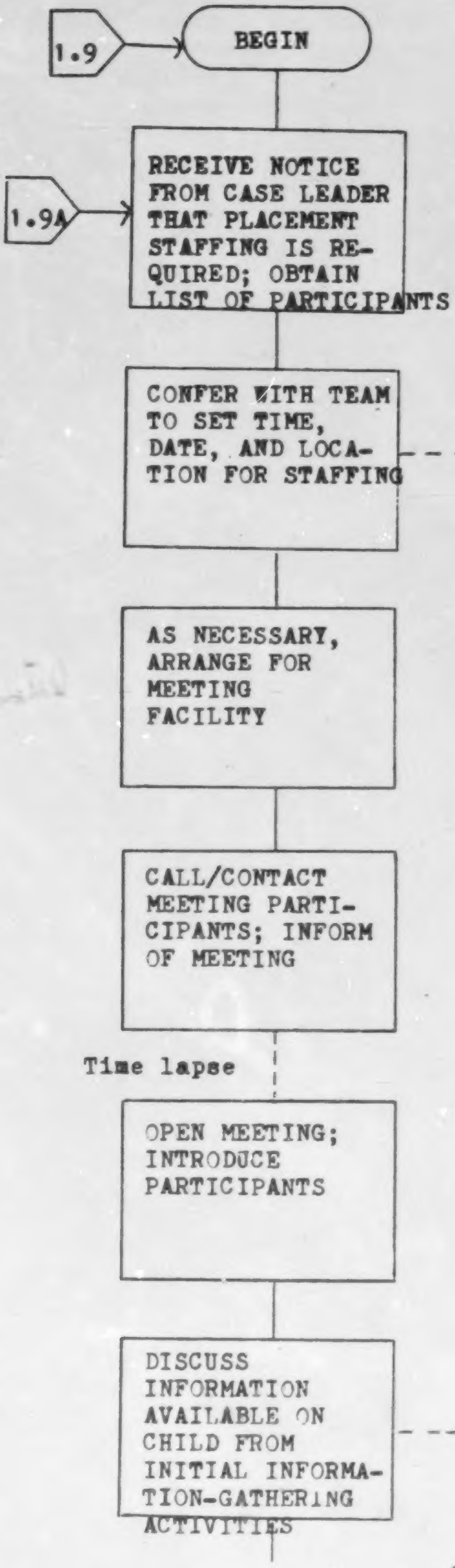

1.8
BEGIN
Case Leader
Diagnostic Team
READ/REVIEW CASE RECORD MATERIALS
Referral Form
Initial Information-Gathering Checklist
Child Observation Record
Home Call Checklist
Notes
AS NEEDED, CONFER WITH TEAM MEMBERS/ PROGRAM COORDINATOR
See 2.7
IS CHILD IN NEED OF INTENSIVE EVALUATION WHICH CAN BEST BE ACCOMPLISHED IN DIAGNOSTIC CLASSROOM?
No
Yes
IS ON-SITE DIAGNOSIS OR PROGRAMMING REQUIRED?
Yes
No
INITIATE/CONTINUE ON-SITE DIAGNOSTIC SERVICES
See 2.1
ENTER CASE DISPOSITION ON MASTER CLIENT REGISTRY
Master Client Registry (see p.161)
END
INFORM PROGRAM COORDINATOR THAT PLACEMENT STAFFING IS REQUIRED; PROVIDE LIST OF PARTICIPANTS
See 1.9A
INFORM PROGRAM COORDINATOR THAT EXIT STAFFING IS REQUIRED; PROVIDE LIST OF PARTICIPANTS
See 1.9A
PARTICIPATE IN PLACEMENT STAFFING
See 1.9
END
PARTICIPATE IN EXIT STAFFING
See 4.5
END

Chart 1.9 PLAN/CONDUCT/PARTICIPATE IN PLACEMENT STAFFING

Program Coordinator
Diagnostic Team
Sending School Staff
Parents
Resource Persons/Consultants


1.9
BEGIN
1.9A
RECEIVE NOTICE FROM CASE LEADER THAT PLACEMENT STAFFING IS REQUIRED; OBTAIN LIST OF PARTICIPANTS
CONFER WITH TEAM TO SET TIME, DATE, AND LOCATION FOR STAFFING
AS NECESSARY, ARRANGE FOR MEETING FACILITY
CALL/CONTACT MEETING PARTICIPANTS; INFORM OF MEETING
Time lapse
OPEN MEETING; INTRODUCE PARTICIPANTS
DISCUSS INFORMATION AVAILABLE ON CHILD FROM INITIAL INFORMATION-GATHERING ACTIVITIES

Placement staffings may be held during the time set aside for weekly intake staffings

As applicable, discuss the following diagnostic domains:
1. Motor
2. Sensory/Perceptual
3. Speech and Language
4. Academic
5. Social/Emotional
6. Self-Help

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Chart 1.9 Continued

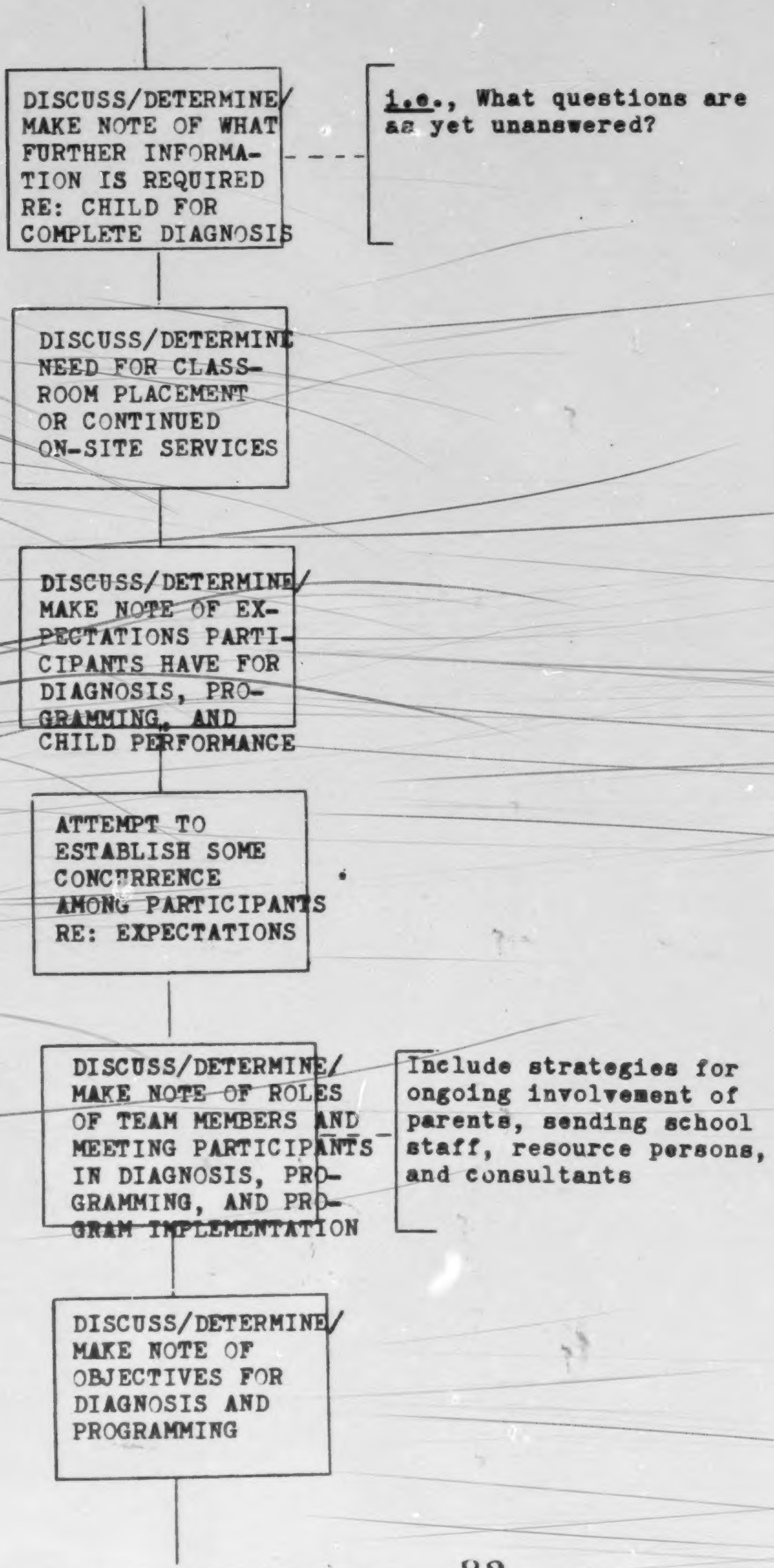
DISCUSS/DETERMINE/ MAKE NOTE OF WHAT FURTHER INFORMATION IS REQUIRED RE: CHILD FOR COMPLETE DIAGNOSIS
i.e., What questions are as yet unanswered?
DISCUSS/DETERMINE NEED FOR CLASSROOM PLACEMENT OR CONTINUED ON-SITE SERVICES
DISCUSS/DETERMINE/ MAKE NOTE OF EXPECTATIONS PARTICIPANTS HAVE FOR DIAGNOSIS, PROGRAMMING, AND CHILD PERFORMANCE
ATTEMPT TO ESTABLISH SOME CONCURRENCE AMONG PARTICIPANTS RE: EXPECTATIONS
DISCUSS/DETERMINE/ MAKE NOTE OF ROLES OF TEAM MEMBERS AND MEETING PARTICIPANTS IN DIAGNOSIS, PROGRAMMING, AND PROGRAM IMPLEMENTATION
Include strategies for ongoing involvement of parents, sending school staff, resource persons, and consultants
DISCUSS/DETERMINE/ MAKE NOTE OF OBJECTIVES FOR DIAGNOSIS AND PROGRAMMING

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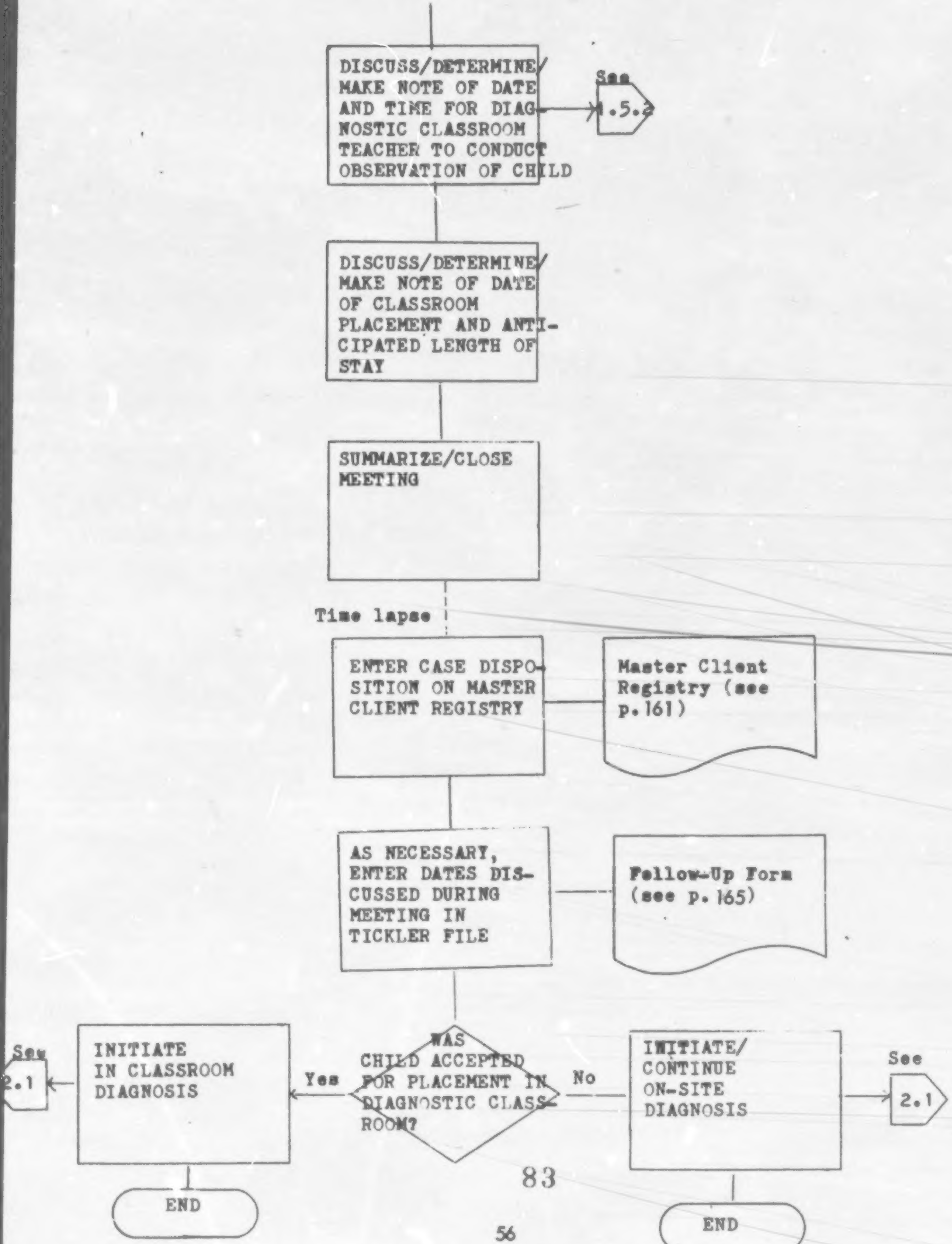
Chart 1.9 Continued


DISCUSS/DETERMINE/ MAKE NOTE OF DATE AND TIME FOR DIAGNOSTIC CLASSROOM TEACHER TO CONDUCT OBSERVATION OF CHILD
See
1.5.2
DISCUSS/DETERMINE/ MAKE NOTE OF DATE OF CLASSROOM PLACEMENT AND ANTICIPATED LENGTH OF STAY
SUMMARIZE/CLOSE MEETING
Time lapse
ENTER CASE DISPOSITION ON MASTER CLIENT REGISTRY
Master Client Registry (see p.161)
AS NECESSARY, ENTER DATES DISCUSSED DURING MEETING IN TICKLER FILE
Follow-Up Form (see p. 165)
WAS CHILD ACCEPTED FOR PLACEMENT IN DIAGNOSTIC CLASSROOM?
Yes
No
INITIATE IN CLASSROOM DIAGNOSIS
See
2.1
END
INITIATE/ CONTINUE ON-SITE DIAGNOSIS
See
2.1
END

Phase 2: ON-SITE OR IN-CLASSROOM DIAGNOSIS

Objectives:

1. To conduct, through the use of formal and informal tests, classroom observation, and medical and other consultants, a complete diagnosis of the child's handicaps across all diagnostic domains.
2. To devise and implement Diagnostic Team Objectives.
3. To devise and implement a Change Plan for the child.
4. To organize and evaluate all diagnostic information.
5. To form diagnostic conclusions.

Initiating Event: Decision to initiate deliver of on-site or in-classroom services

Terminating Event: Completion of Diagnostic Summary

OVERVIEW OF PHASE 2: ON-SITE OR IN-CLASSROOM DIAGNOSIS

Cf:	BEGIN	Staff:
Chart 2.1	DEVISE/ PRIORITIZE/ SEQUENCE DIAGNOSTIC TEAM OBJECTIVES	Case Leader Diagnostic Team
Chart 2.2	DEVISE/ IMPLEMENT CHANGE PLAN	Case Leader (On-Site) Diagnostic Classroom Teacher (In-Classroom)
Chart 2.3	ARRANGE FOR USE OF MEDICAL AND OTHER CONSULTANTS	Case Leader (On-Site) Diagnostic Classroom Teacher (In-Classroom)
Chart 2.4	ARRANGE FOR USE OF RESOURCE PERSONS IN DIAGNOSIS	Case Leader (On-Site) Diagnostic Classroom Teacher (In-Classroom)
Chart 2.5	SELECT/ ADMINISTER/ INTERPRET FORMAL DIAGNOSTIC TESTS	Case Leader (On-Site) Diagnostic Classroom Teacher (In-Classroom)

Continued on next page

Phase 2 Overview Chart, Continued

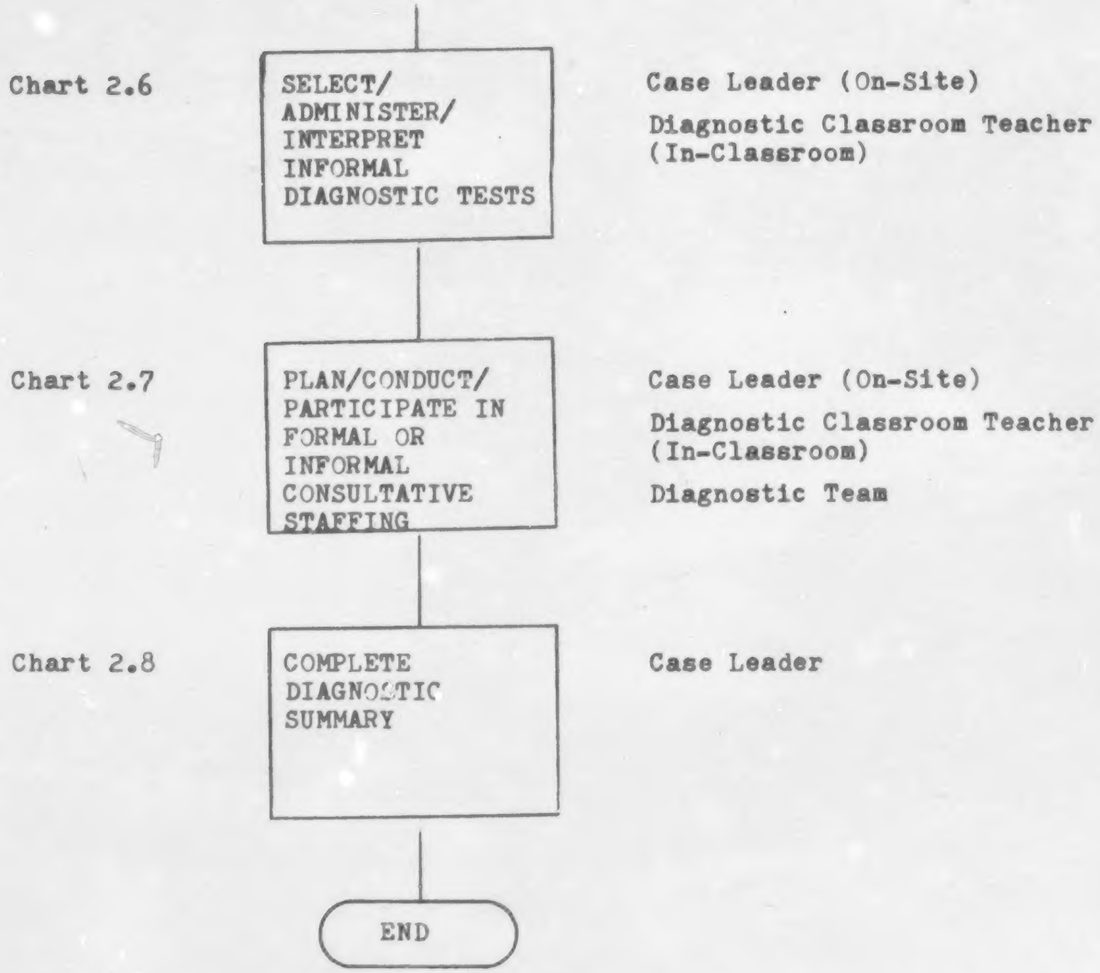
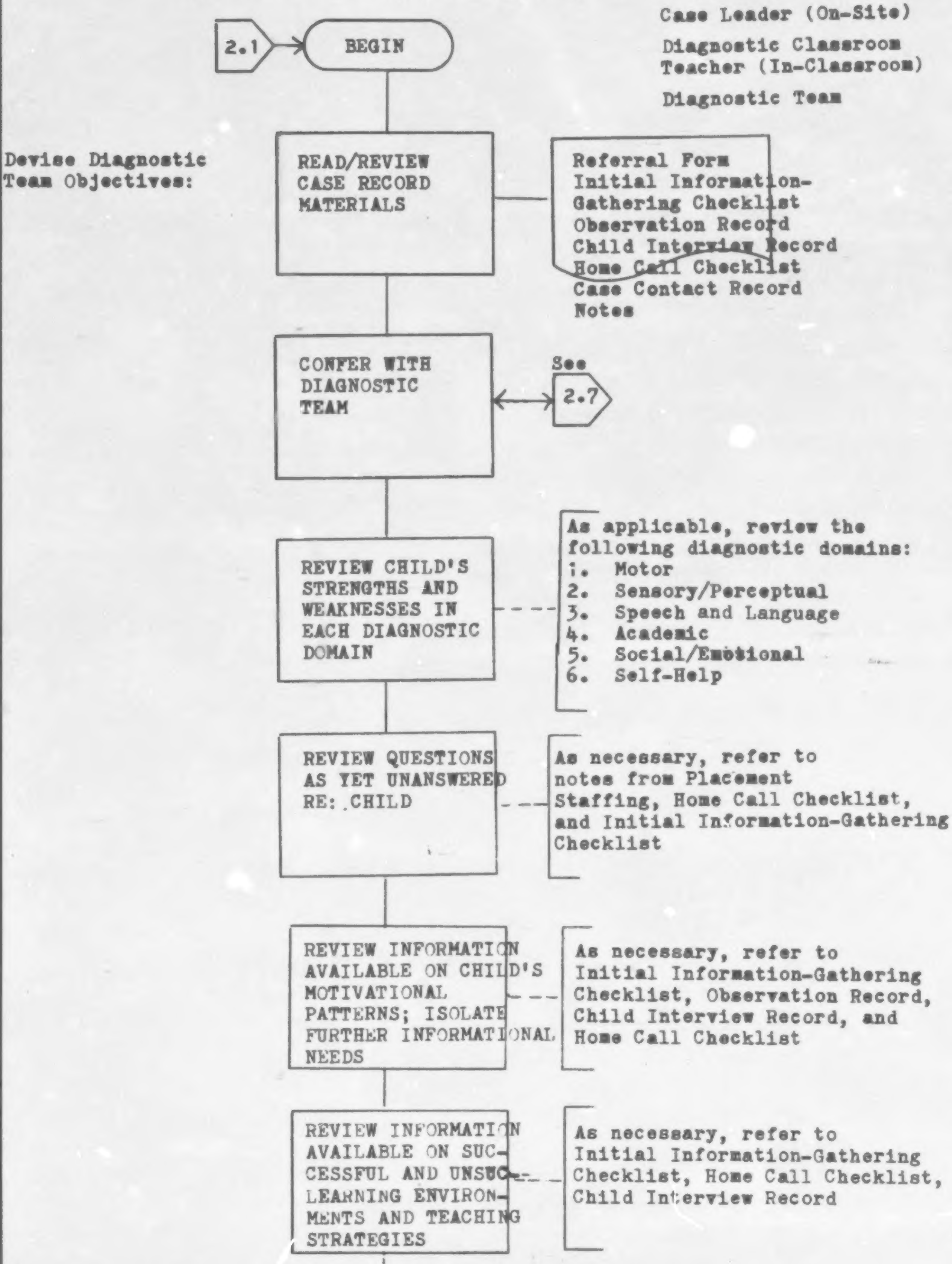


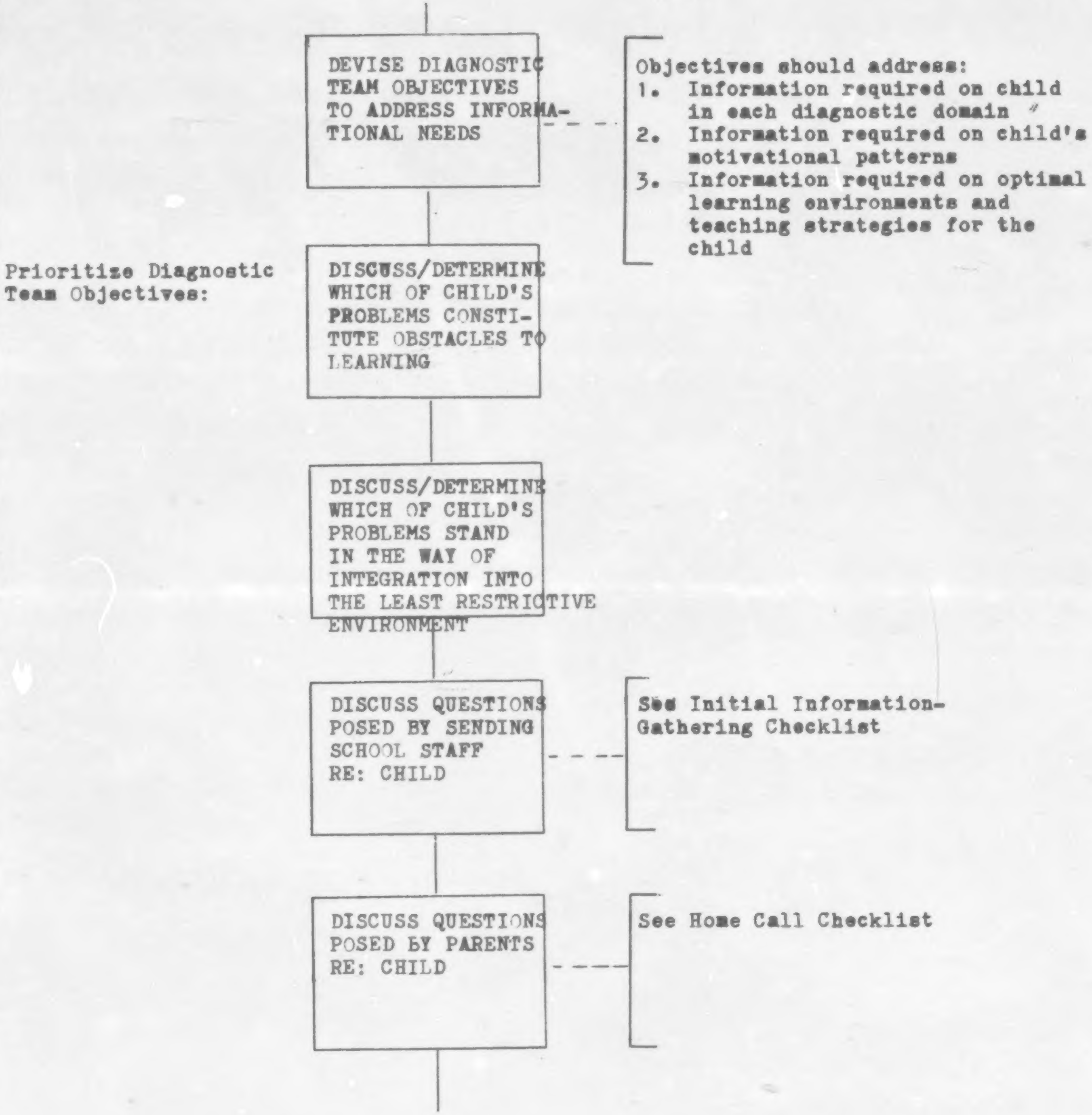
Chart 2.6
SELECT/ ADMINISTER/ INTERPRET INFORMAL DIAGNOSTIC TESTS
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Chart 2.7
PLAN/CONDUCT/ PARTICIPATE IN FORMAL OR INFORMAL CONSULTATIVE STAFFING
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Diagnostic Team
Chart 2.8
COMPLETE DIAGNOSTIC SUMMARY
Case Leader
END

Chart 2.1 DEVISE/PRIORITIZE/SEQUENCE DIAGNOSTIC TEAM OBJECTIVES


Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Diagnostic Team
2.1
BEGIN
Devise Diagnostic Team Objectives:
READ/REVIEW CASE RECORD MATERIALS
Referral Form
Initial Information-Gathering Checklist
Observation Record
Child Interview Record
Home Call Checklist
Case Contact Record
Notes
CONFER WITH DIAGNOSTIC TEAM
See
2.7
REVIEW CHILD'S STRENGTHS AND WEAKNESSES IN EACH DIAGNOSTIC DOMAIN
As applicable, review the following diagnostic domains:
1. Motor
2. Sensory/Perceptual
3. Speech and Language
4. Academic
5. Social/Emotional
6. Self-Help
REVIEW QUESTIONS AS YET UNANSWERED RE: CHILD
As necessary, refer to notes from Placement Staffing, Home Call Checklist, and Initial Information-Gathering Checklist
REVIEW INFORMATION AVAILABLE ON CHILD'S MOTIVATIONAL PATTERNS; ISOLATE FURTHER INFORMATIONAL NEEDS
As necessary, refer to Initial Information-Gathering Checklist, Observation Record, Child Interview Record, and Home Call Checklist
REVIEW INFORMATION AVAILABLE ON SUCCESSFUL AND UNSUCC- LEARNING ENVIRONMENTS AND TEACHING STRATEGIES
As necessary, refer to Initial Information-Gathering Checklist, Home Call Checklist, Child Interview Record

Continued on next page

Chart 2.1 Continued


DEVISE DIAGNOSTIC TEAM OBJECTIVES TO ADDRESS INFORMATIONAL NEEDS
DISCUSS/DETERMINE WHICH OF CHILD'S PROBLEMS CONSTITUTE OBSTACLES TO LEARNING
DISCUSS/DETERMINE WHICH OF CHILD'S PROBLEMS STAND IN THE WAY OF INTEGRATION INTO THE LEAST RESTRICTIVE ENVIRONMENT
DISCUSS QUESTIONS POSED BY SENDING SCHOOL STAFF RE: CHILD
DISCUSS QUESTIONS POSED BY PARENTS RE: CHILD

Objectives should address:
1. Information required on child in each diagnostic domain
2. Information required on child's motivational patterns
3. Information required on optimal learning environments and teaching strategies for the child

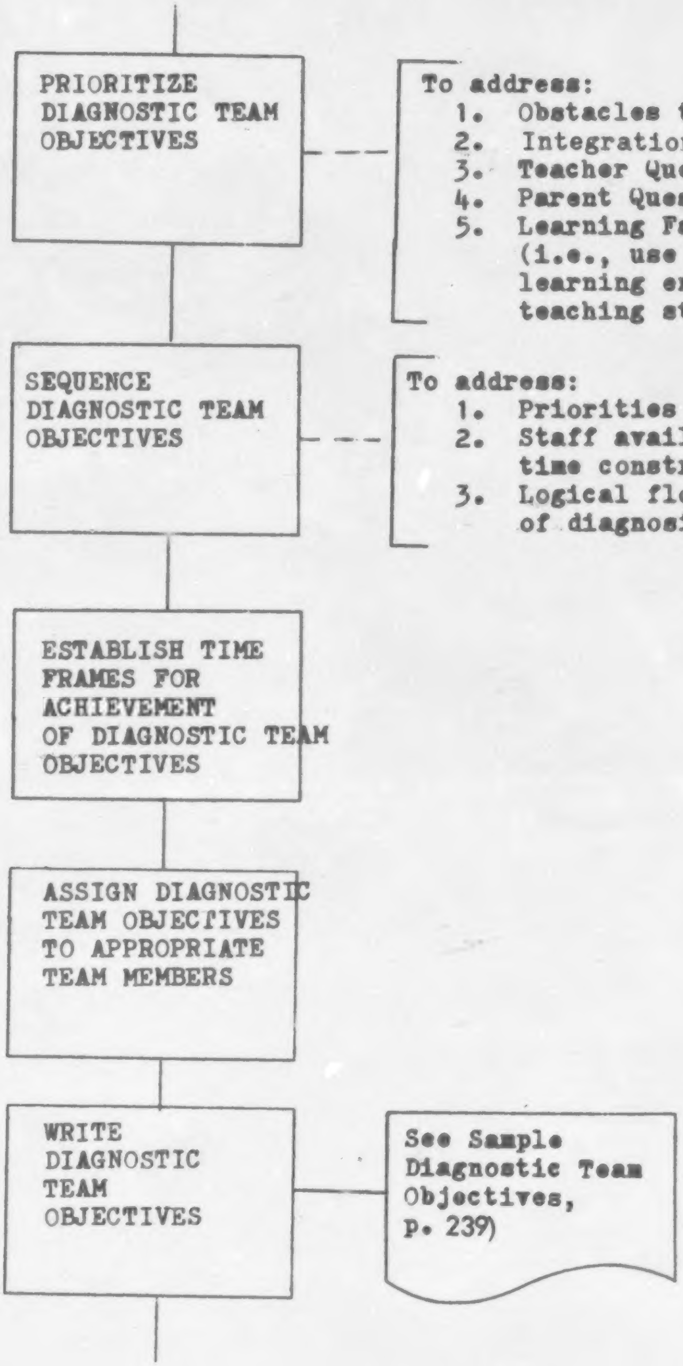
Prioritize Diagnostic Team Objectives:

See Initial Information-Gathering Checklist

See Home Call Checklist

Continued on next page

Chart 2.1 Continued


PRIORITIZE DIAGNOSTIC TEAM OBJECTIVES
SEQUENCE DIAGNOSTIC TEAM OBJECTIVES
ESTABLISH TIME FRAMES FOR ACHIEVEMENT OF DIAGNOSTIC TEAM OBJECTIVES
ASSIGN DIAGNOSTIC TEAM OBJECTIVES TO APPROPRIATE TEAM MEMBERS
WRITE DIAGNOSTIC TEAM OBJECTIVES
See Sample Diagnostic Team Objectives, p. 239)

To address:
1. Obstacles to learning
2. Integration needs
3. Teacher Questions
4. Parent Questions
5. Learning Facilitation (i.e., use of reinforcers, learning environments, and teaching strategies

Sequence Diagnostic Team Objectives:

To address:
1. Priorities
2. Staff availability and time constraints
3. Logical flow in process of diagnosis

Continued on next page

Chart 2.1 Continued

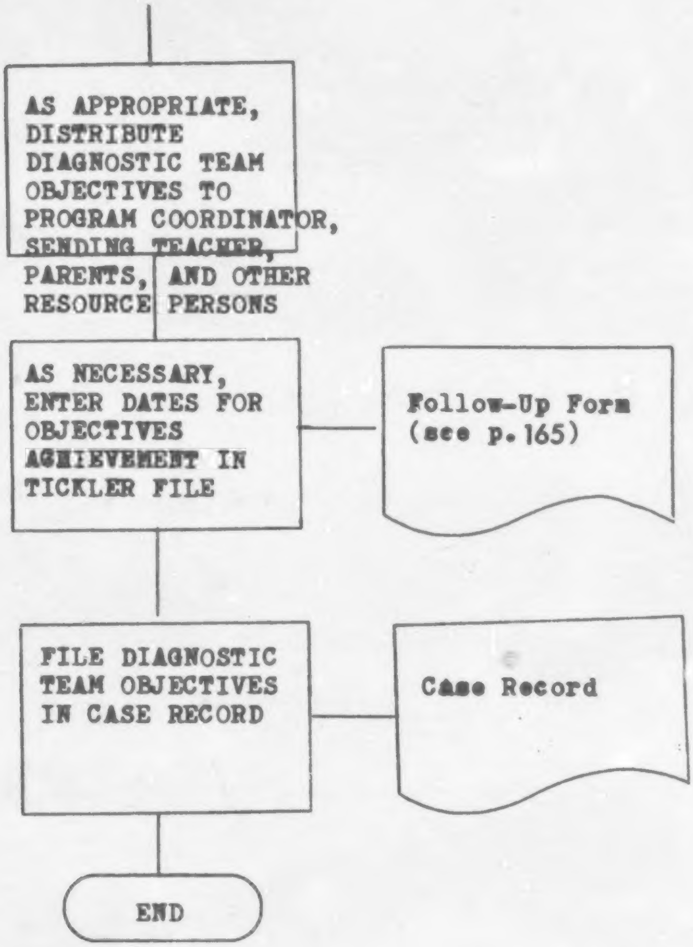
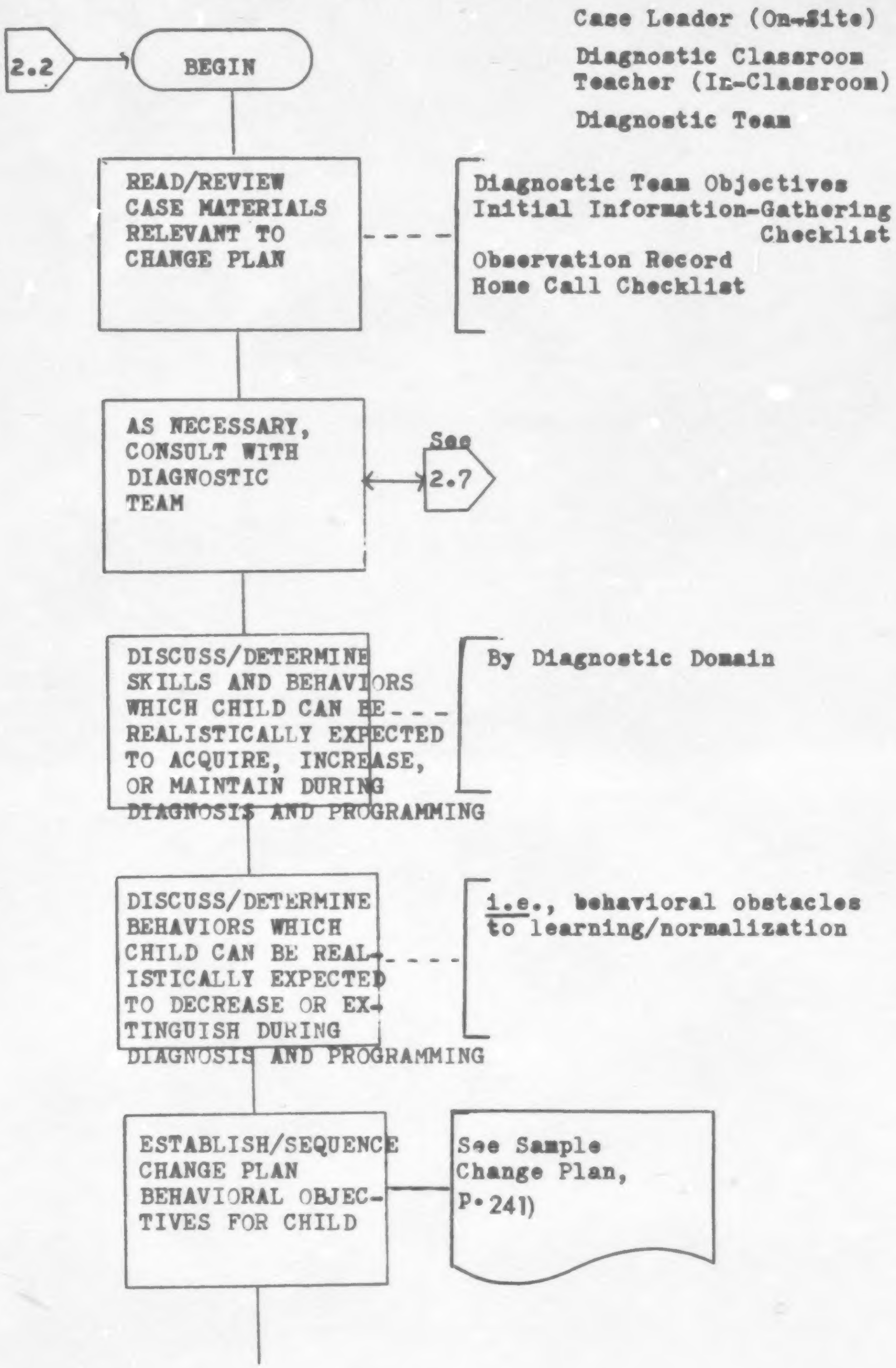

AS APPROPRIATE, DISTRIBUTE DIAGNOSTIC TEAM OBJECTIVES TO PROGRAM COORDINATOR, SENDING TEACHER, PARENTS, AND OTHER RESOURCE PERSONS
AS NECESSARY, ENTER DATES FOR OBJECTIVES ACHIEVEMENT IN TICKLER FILE
Follow-Up Form (see p. 165)
FILE DIAGNOSTIC TEAM OBJECTIVES IN CASE RECORD
Case Record
END

Chart 2.2 DEVISE/IMPLEMENT CHANGE PLAN


Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Diagnostic Team
2.2
BEGIN
READ/REVIEW CASE MATERIALS RELEVANT TO CHANGE PLAN
Diagnostic Team Objectives
Initial Information-Gathering Checklist
Observation Record
Home Call Checklist
AS NECESSARY, CONSULT WITH DIAGNOSTIC TEAM
See 2.7
DISCUSS/DETERMINE SKILLS AND BEHAVIORS WHICH CHILD CAN BE REALISTICALLY EXPECTED TO ACQUIRE, INCREASE, OR MAINTAIN DURING DIAGNOSIS AND PROGRAMMING
By Diagnostic Domain
DISCUSS/DETERMINE BEHAVIORS WHICH CHILD CAN BE REALISTICALLY EXPECTED TO DECREASE OR EXTINGUISH DURING DIAGNOSIS AND PROGRAMMING
i.e., behavioral obstacles to learning/normalization
ESTABLISH/SEQUENCE CHANGE PLAN BEHAVIORAL OBJECTIVES FOR CHILD
See Sample Change Plan, P. 241)

Continued on next page

Chart 2.2 Continued

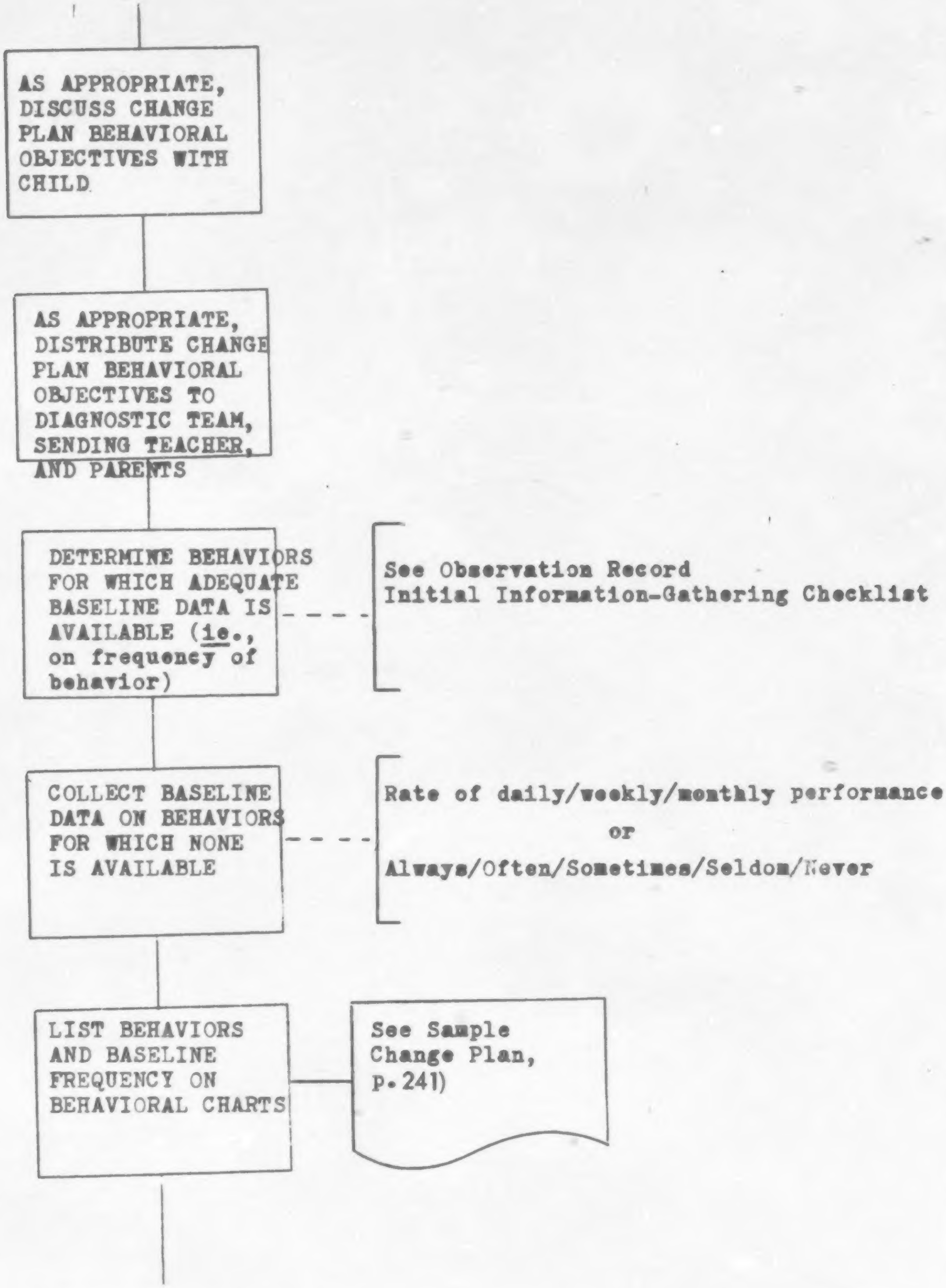

AS APPROPRIATE, DISCUSS CHANGE PLAN BEHAVIORAL OBJECTIVES WITH CHILD
AS APPROPRIATE, DISTRIBUTE CHANGE PLAN BEHAVIORAL OBJECTIVES TO DIAGNOSTIC TEAM, SENDING TEACHER, AND PARENTS
DETERMINE BEHAVIORS FOR WHICH ADEQUATE BASELINE DATA IS AVAILABLE (ie., on frequency of behavior)
See Observation Record
Initial Information-Gathering Checklist
COLLECT BASELINE DATA ON BEHAVIORS FOR WHICH NONE IS AVAILABLE
Rate of daily/weekly/monthly performance
or
Always/Often/Sometimes/Seldom/Never
LIST BEHAVIORS AND BASELINE FREQUENCY ON BEHAVIORAL CHARTS
See Sample Change Plan, p. 241)

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Chart 2.2 Continued

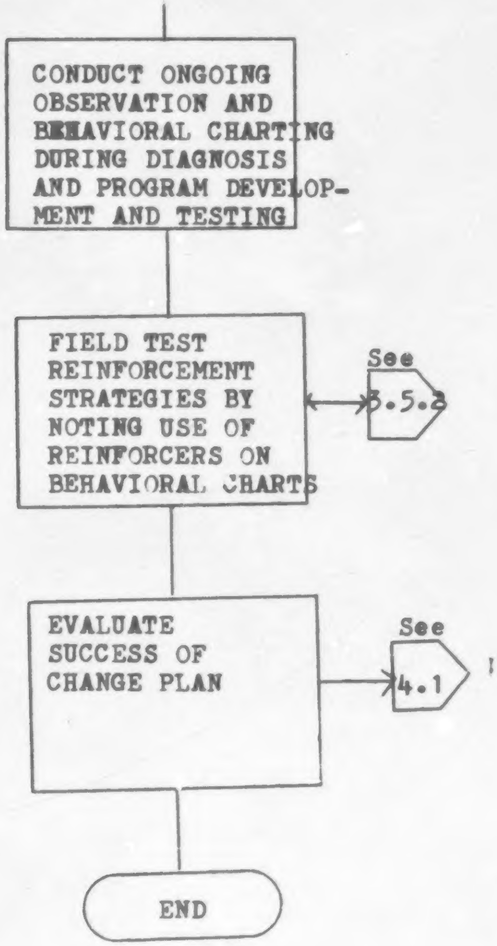
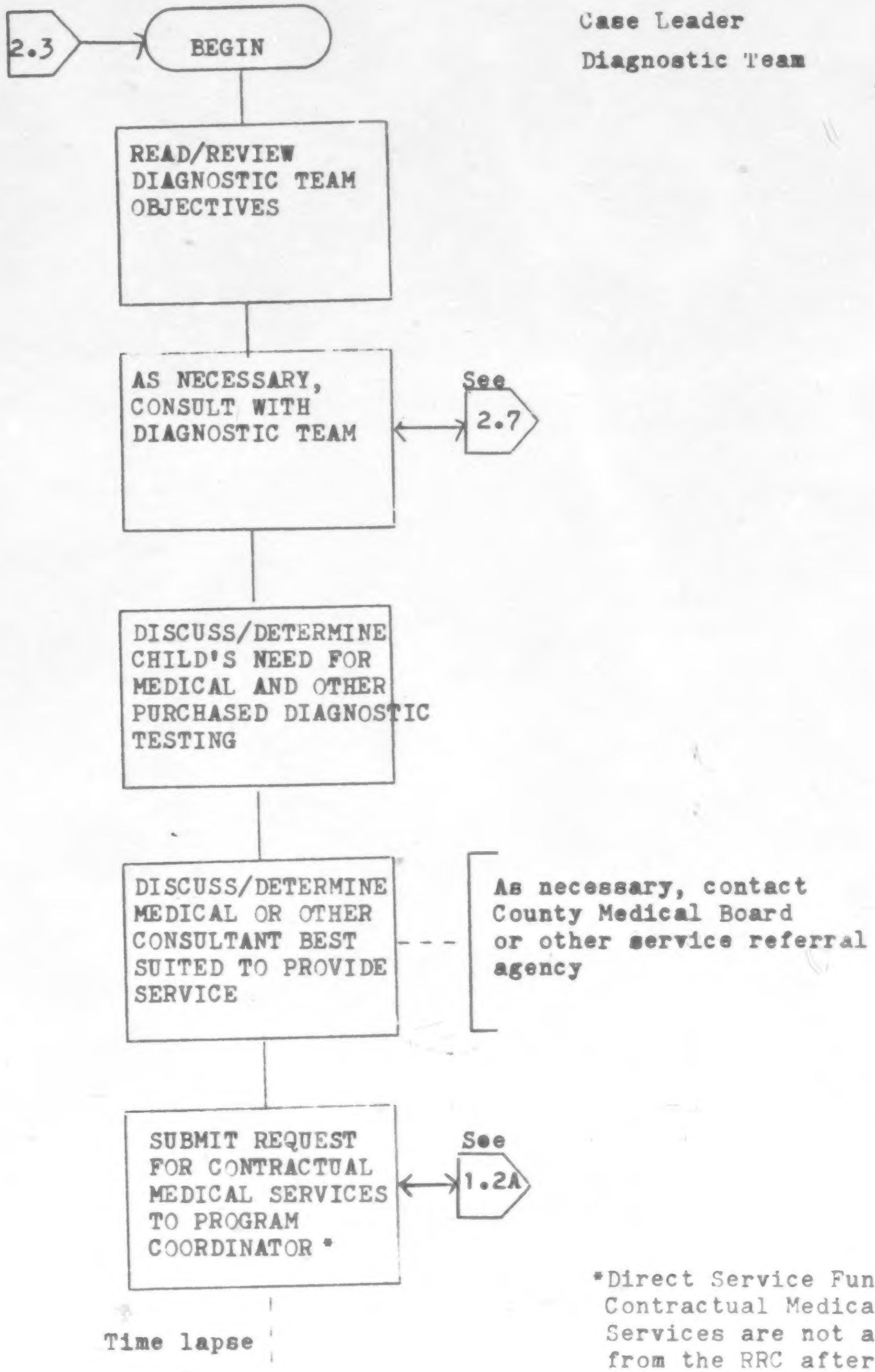

CONDUCT ONGOING OBSERVATION AND BEHAVIORAL CHARTING DURING DIAGNOSIS AND PROGRAM DEVELOPMENT AND TESTING
FIELD TEST REINFORCEMENT STRATEGIES BY NOTING USE OF REINFORCERS ON BEHAVIORAL CHARTS
See
3.5.2
EVALUATE SUCCESS OF CHANGE PLAN
See
4.1
END

Chart 2.3 ARRANGE FOR USE OF MEDICAL AND OTHER CONSULTANTS


Case Leader
Diagnostic Team
2.3
BEGIN
READ/REVIEW DIAGNOSTIC TEAM OBJECTIVES
AS NECESSARY, CONSULT WITH DIAGNOSTIC TEAM
See
2.7
DISCUSS/DETERMINE CHILD'S NEED FOR MEDICAL AND OTHER PURCHASED DIAGNOSTIC TESTING
DISCUSS/DETERMINE MEDICAL OR OTHER CONSULTANT BEST SUITED TO PROVIDE SERVICE
As necessary, contact County Medical Board or other service referral agency
SUBMIT REQUEST FOR CONTRACTUAL MEDICAL SERVICES TO PROGRAM COORDINATOR *
See
1.2A
Time lapse

*Direct Service Funds for Contractual Medical Services are not available from the RRC after January 31, 1977.

Continued on next page

Chart 2.3 Continued

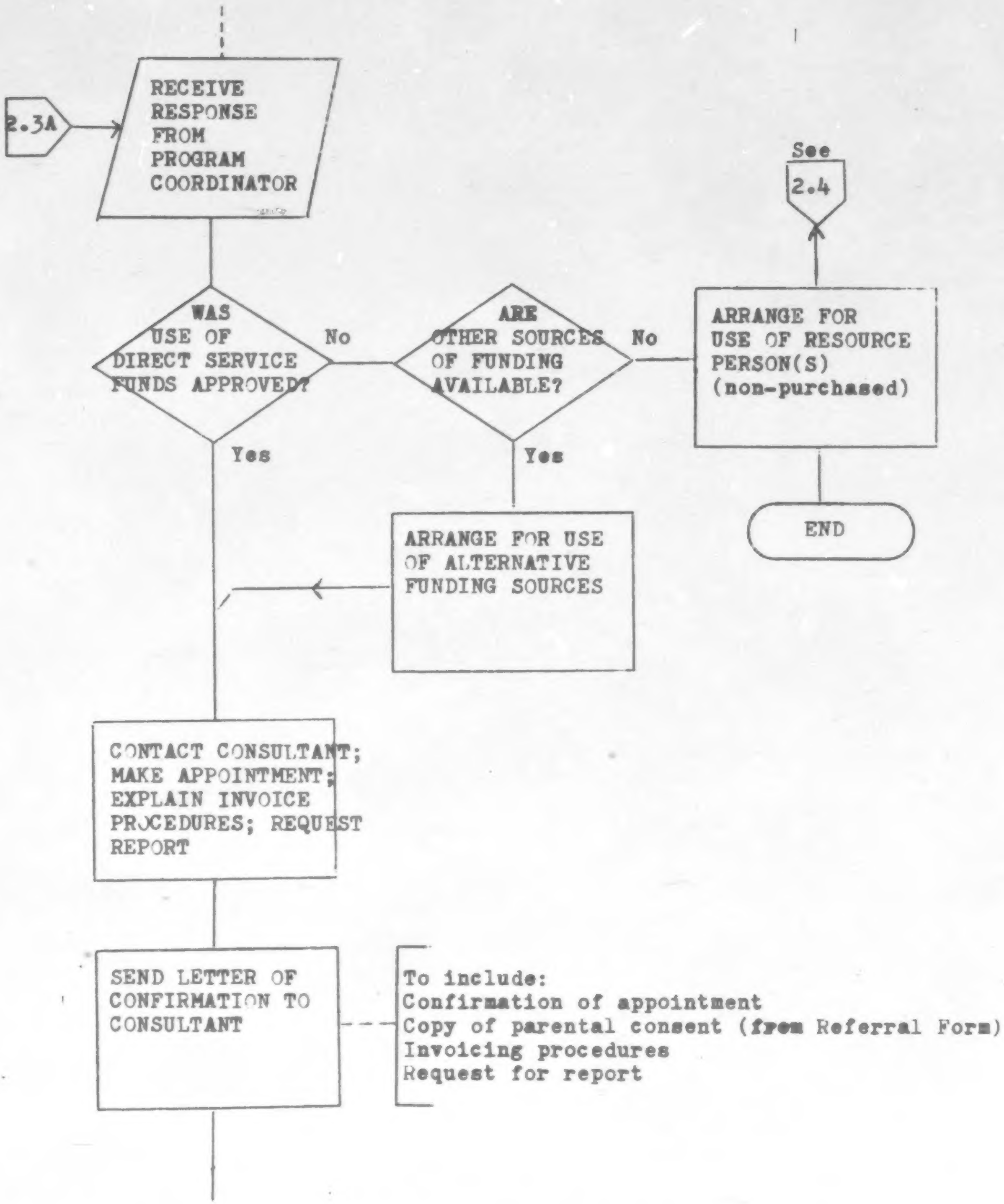

2.3A
RECEIVE RESPONSE FROM PROGRAM COORDINATOR
WAS USE OF DIRECT SERVICE FUNDS APPROVED?
No
Yes
ARE OTHER SOURCES OF FUNDING AVAILABLE?
No
Yes
ARRANGE FOR USE OF RESOURCE PERSON(S) (non-purchased)
See
2.4
END
ARRANGE FOR USE OF ALTERNATIVE FUNDING SOURCES
CONTACT CONSULTANT; MAKE APPOINTMENT; EXPLAIN INVOICE PROCEDURES; REQUEST REPORT
SEND LETTER OF CONFIRMATION TO CONSULTANT
To include:
Confirmation of appointment
Copy of parental consent (from Referral Form)
Invoicing procedures
Request for report

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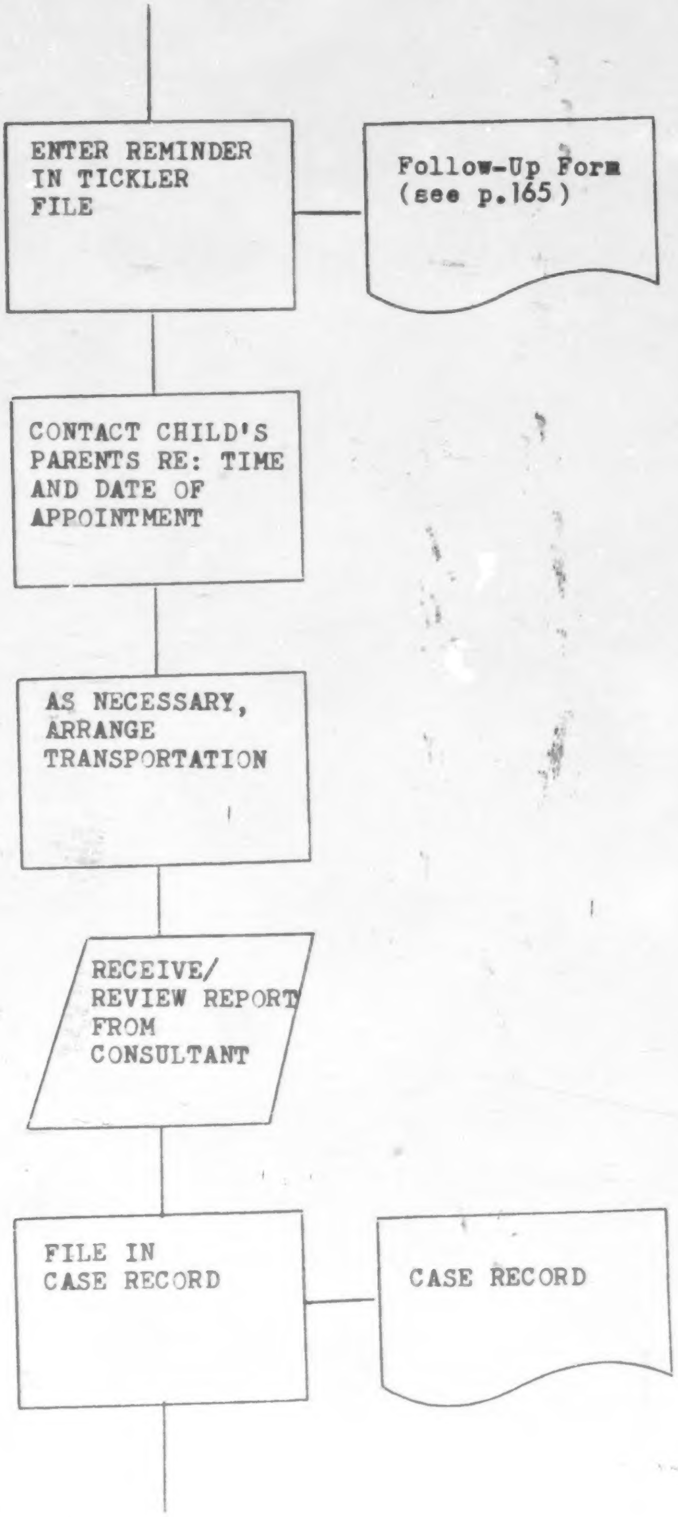
Chart 2.3 Continued


ENTER REMINDER IN TICKLER FILE
Follow-Up Form (see p.165)
CONTACT CHILD'S PARENTS RE: TIME AND DATE OF APPOINTMENT
AS NECESSARY, ARRANGE TRANSPORTATION
RECEIVE/ REVIEW REPORT FROM CONSULTANT
FILE IN CASE RECORD
CASE RECORD

Continued on next page

Page three of four

Chart 2.3 Continued

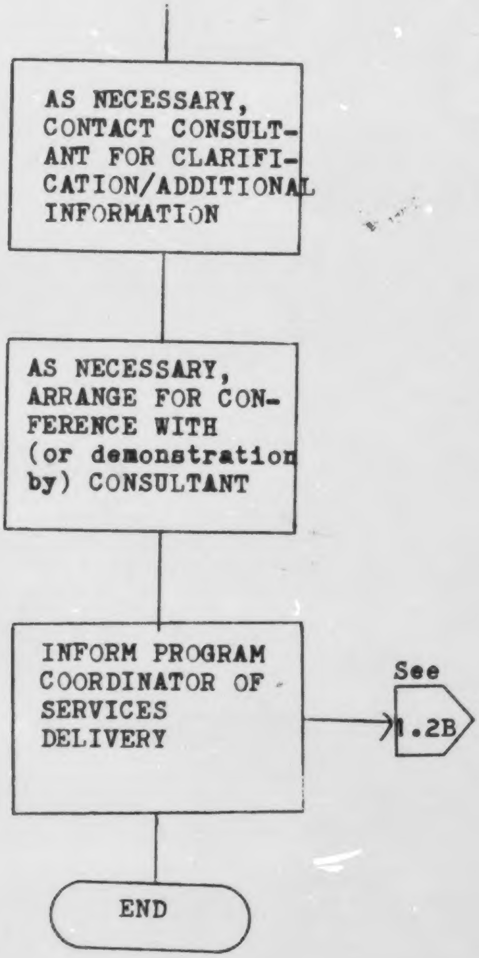
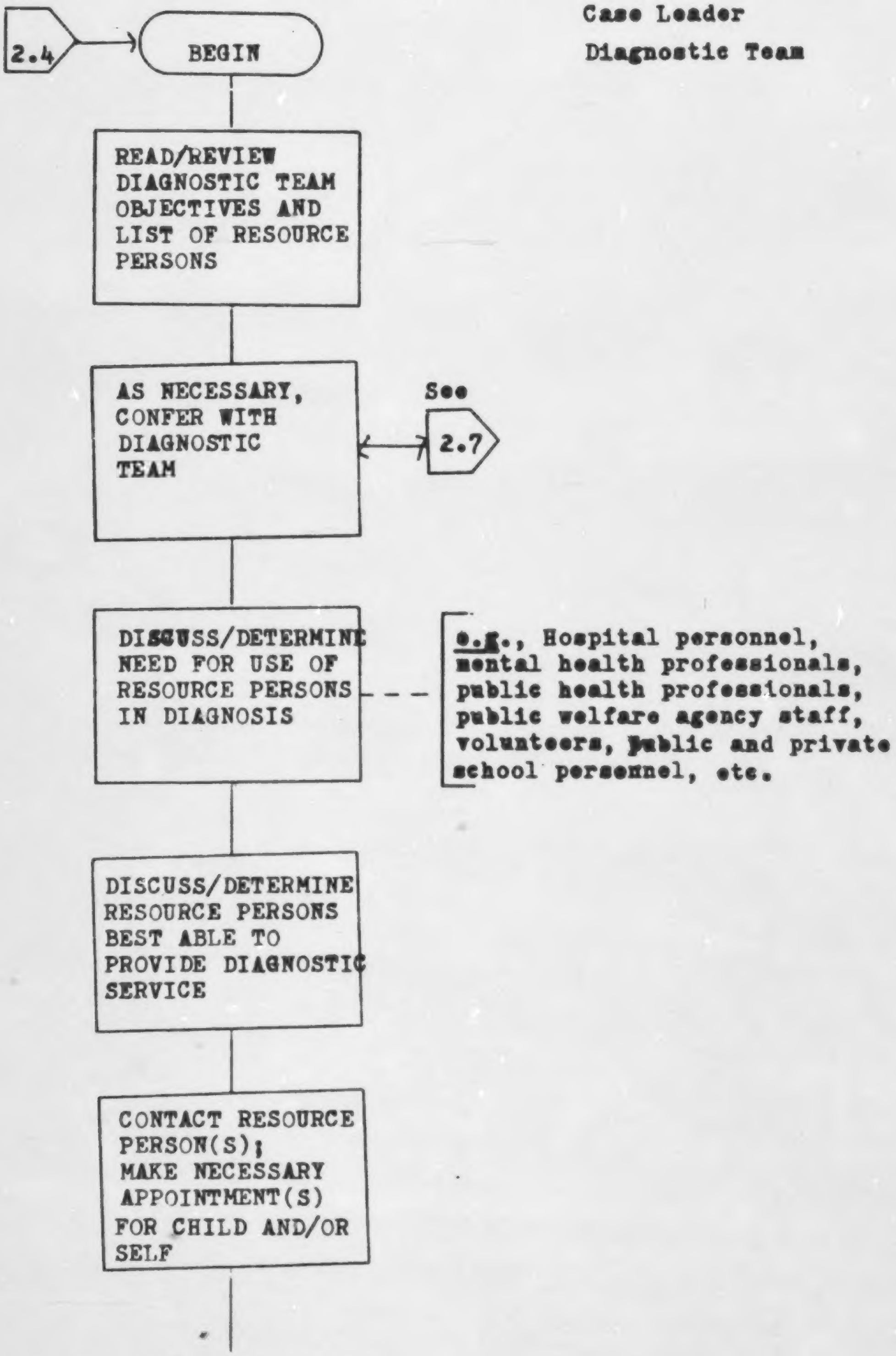

AS NECESSARY, CONTACT CONSULTANT FOR CLARIFICATION/ADDITIONAL INFORMATION
AS NECESSARY, ARRANGE FOR CONFERENCE WITH (or demonstration by) CONSULTANT
INFORM PROGRAM COORDINATOR OF SERVICES DELIVERY
See
1.2B
END

Chart 2.4 ARRANGE FOR USE OF RESOURCE PERSONS IN DIAGNOSIS

Case Leader

Diagnostic Team

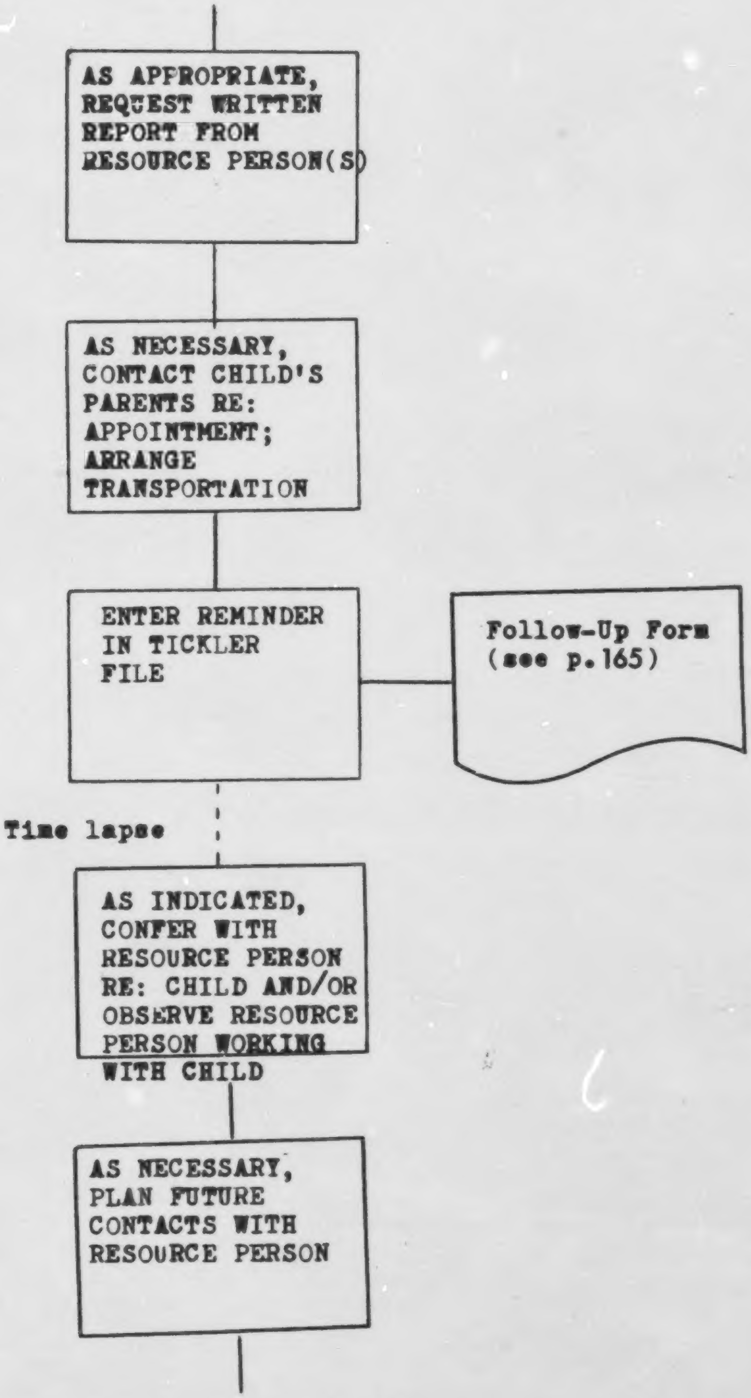

2.4
BEGIN
READ/REVIEW DIAGNOSTIC TEAM OBJECTIVES AND LIST OF RESOURCE PERSONS
AS NECESSARY, CONFER WITH DIAGNOSTIC TEAM
See
2.7
DISCUSS/DETERMINE NEED FOR USE OF RESOURCE PERSONS IN DIAGNOSIS
DISCUSS/DETERMINE RESOURCE PERSONS BEST ABLE TO PROVIDE DIAGNOSTIC SERVICE
CONTACT RESOURCE PERSON(S); MAKE NECESSARY APPOINTMENT(S) FOR CHILD AND/OR SELF

e.g., Hospital personnel, mental health professionals, public health professionals, public welfare agency staff, volunteers, public and private school persennel, etc.

Continued on next page

Page one of three

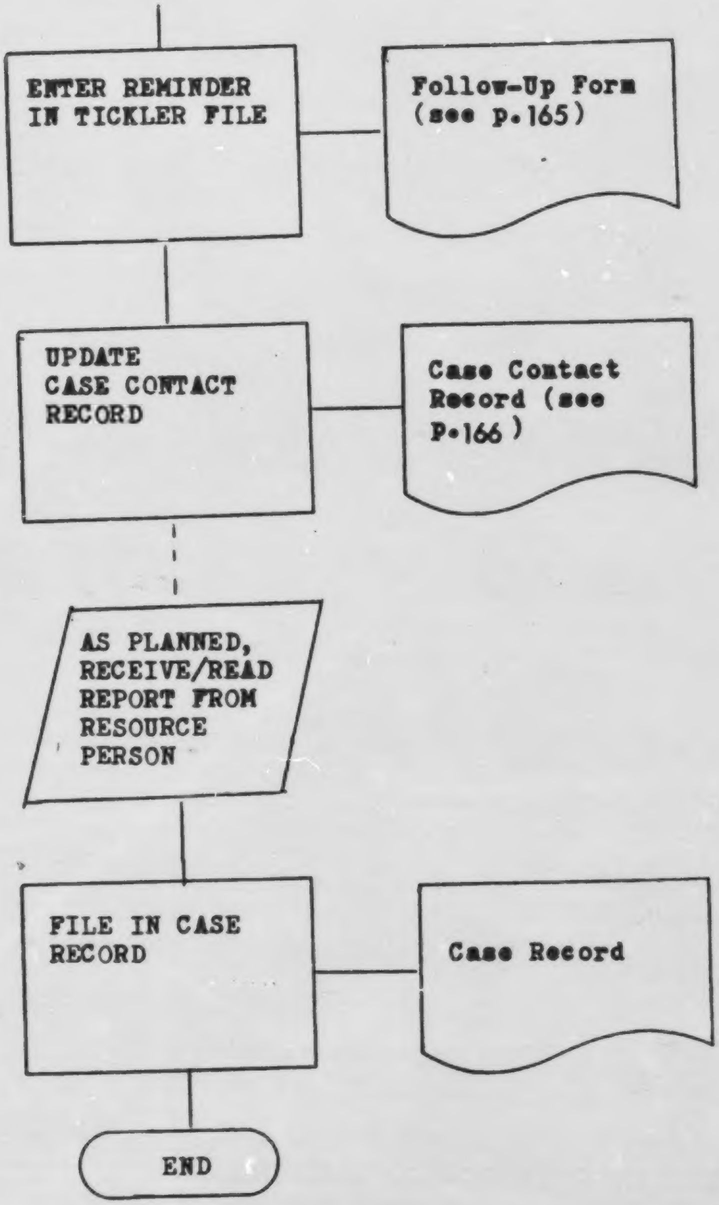
Chart 2.4 Continued


AS APPROPRIATE, REQUEST WRITTEN REPORT FROM RESOURCE PERSON(S)
AS NECESSARY, CONTACT CHILD'S PARENTS RE: APPOINTMENT; ARRANGE TRANSPORTATION
ENTER REMINDER IN TICKLER FILE
Follow-Up Form (see p.165)
Time lapse
AS INDICATED, CONFER WITH RESOURCE PERSON RE: CHILD AND/OR OBSERVE RESOURCE PERSON WORKING WITH CHILD
AS NECESSARY, PLAN FUTURE CONTACTS WITH RESOURCE PERSON

Continued on next page

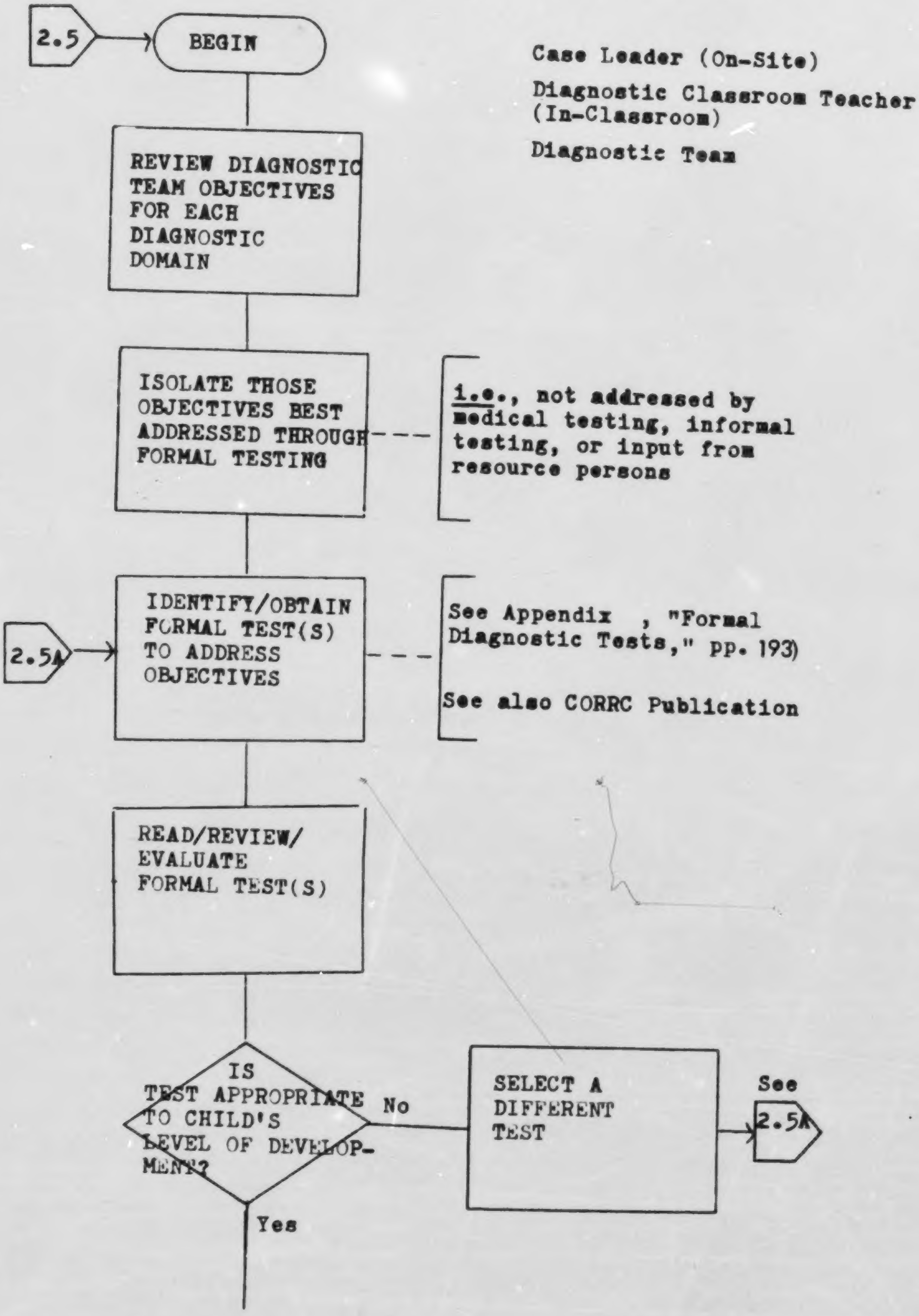
Page two of three

Chart 2.4 Continued


ENTER REMINDER IN TICKLER FILE
Follow-Up Form (see p.165)
UPDATE CASE CONTACT RECORD
Case Contact Record (see p.166)
AS PLANNED, RECEIVE/READ REPORT FROM RESOURCE PERSON
FILE IN CASE RECORD
Case Record
END

Page three of three

Chart 2.5 SELECT/ADMINISTER/INTERPRET FORMAL DIAGNOSTIC TESTS


2.5
BEGIN
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Diagnostic Team
REVIEW DIAGNOSTIC TEAM OBJECTIVES FOR EACH DIAGNOSTIC DOMAIN
ISOLATE THOSE OBJECTIVES BEST ADDRESSED THROUGH FORMAL TESTING
i.e., not addressed by medical testing, informal testing, or input from resource persons
2.5A
IDENTIFY/OBTAIN FORMAL TEST(S) TO ADDRESS OBJECTIVES
See Appendix , "Formal Diagnostic Tests," pp. 193)
See also CORRC Publication
READ/REVIEW/EVALUATE FORMAL TEST(S)
IS TEST APPROPRIATE TO CHILD'S LEVEL OF DEVELOPMENT?
No
SELECT A DIFFERENT TEST
See
2.5A
Yes

Continued on next page

Chart 2.5 Continued

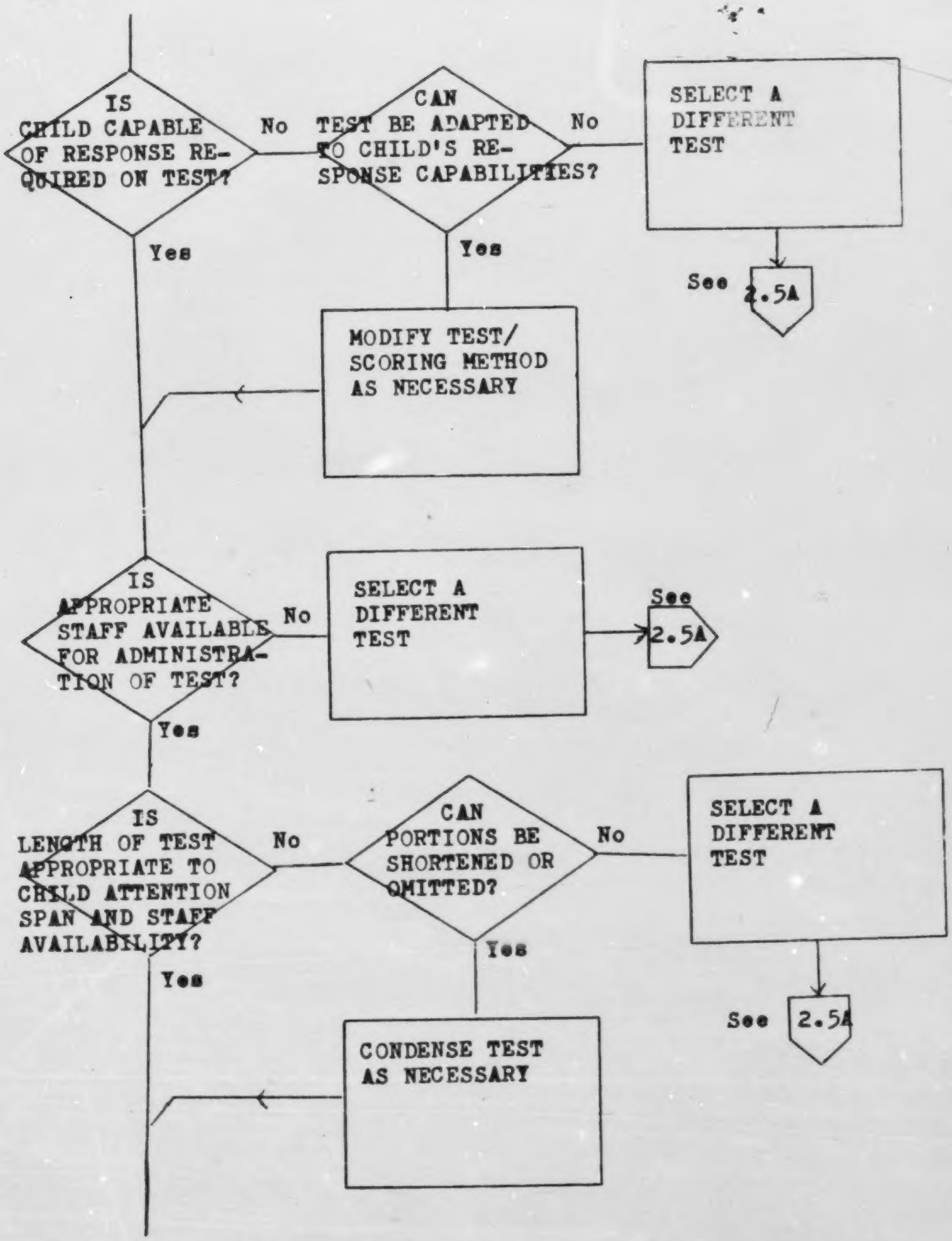

IS CHILD CAPABLE OF RESPONSE REQUIRED ON TEST?
No
CAN TEST BE ADAPTED TO CHILD'S RESPONSE CAPABILITIES?
No
SELECT A DIFFERENT TEST
See 2.5A
Yes
Yes
MODIFY TEST/ SCORING METHOD AS NECESSARY
IS APPROPRIATE STAFF AVAILABLE FOR ADMINISTRATION OF TEST?
No
SELECT A DIFFERENT TEST
See 2.5A
Yes
IS LENGTH OF TEST APPROPRIATE TO CHILD ATTENTION SPAN AND STAFF AVAILABILITY?
No
CAN PORTIONS BE SHORTENED OR OMITTED?
No
SELECT A DIFFERENT TEST
Yes
See 2.5A
Yes
CONDENSE TEST AS NECESSARY

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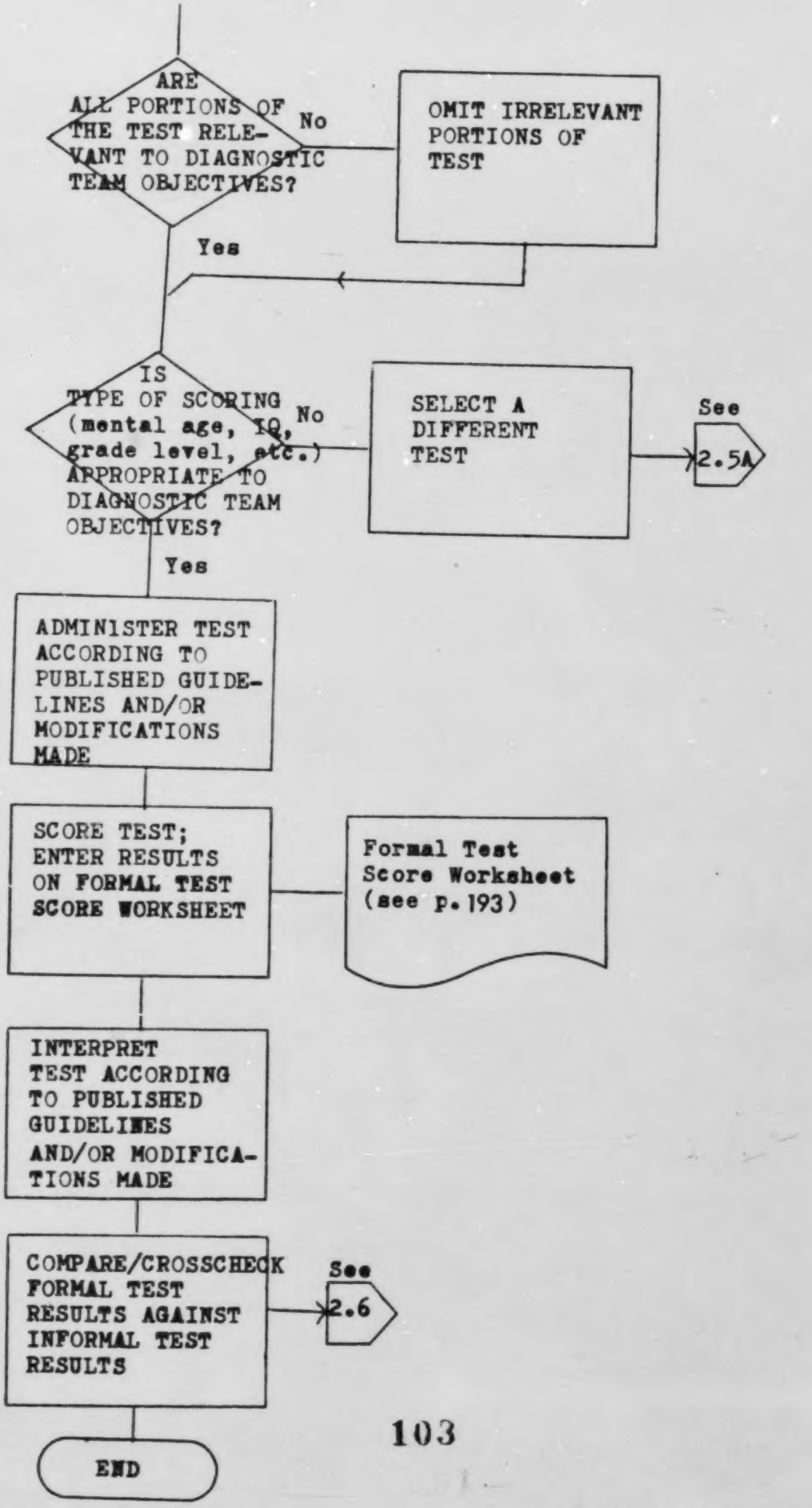
Chart 2.5 Continued


ARE ALL PORTIONS OF THE TEST RELEVANT TO DIAGNOSTIC TEAM OBJECTIVES?
No
OMIT IRRELEVANT PORTIONS OF TEST
Yes
IS TYPE OF SCORING (mental age, IQ, grade level, etc.) APPROPRIATE TO DIAGNOSTIC TEAM OBJECTIVES?
No
SELECT A DIFFERENT TEST
See
2.5A
Yes
ADMINISTER TEST ACCORDING TO PUBLISHED GUIDELINES AND/OR MODIFICATIONS MADE
SCORE TEST; ENTER RESULTS ON FORMAL TEST SCORE WORKSHEET
Formal Test Score Worksheet (see p. 193)
INTERPRET TEST ACCORDING TO PUBLISHED GUIDELINES AND/OR MODIFICATIONS MADE
COMPARE/CROSSCHECK FORMAL TEST RESULTS AGAINST INFORMAL TEST RESULTS
See
2.6
END

Page three of three

Chart 2.6 SELECT/ADMINISTER/INTERPRET INFORMAL DIAGNOSTIC TESTS

Case Leader (On-Site)

Diagnostic Classroom Teacher (In-Classroom)

Diagnostic Team

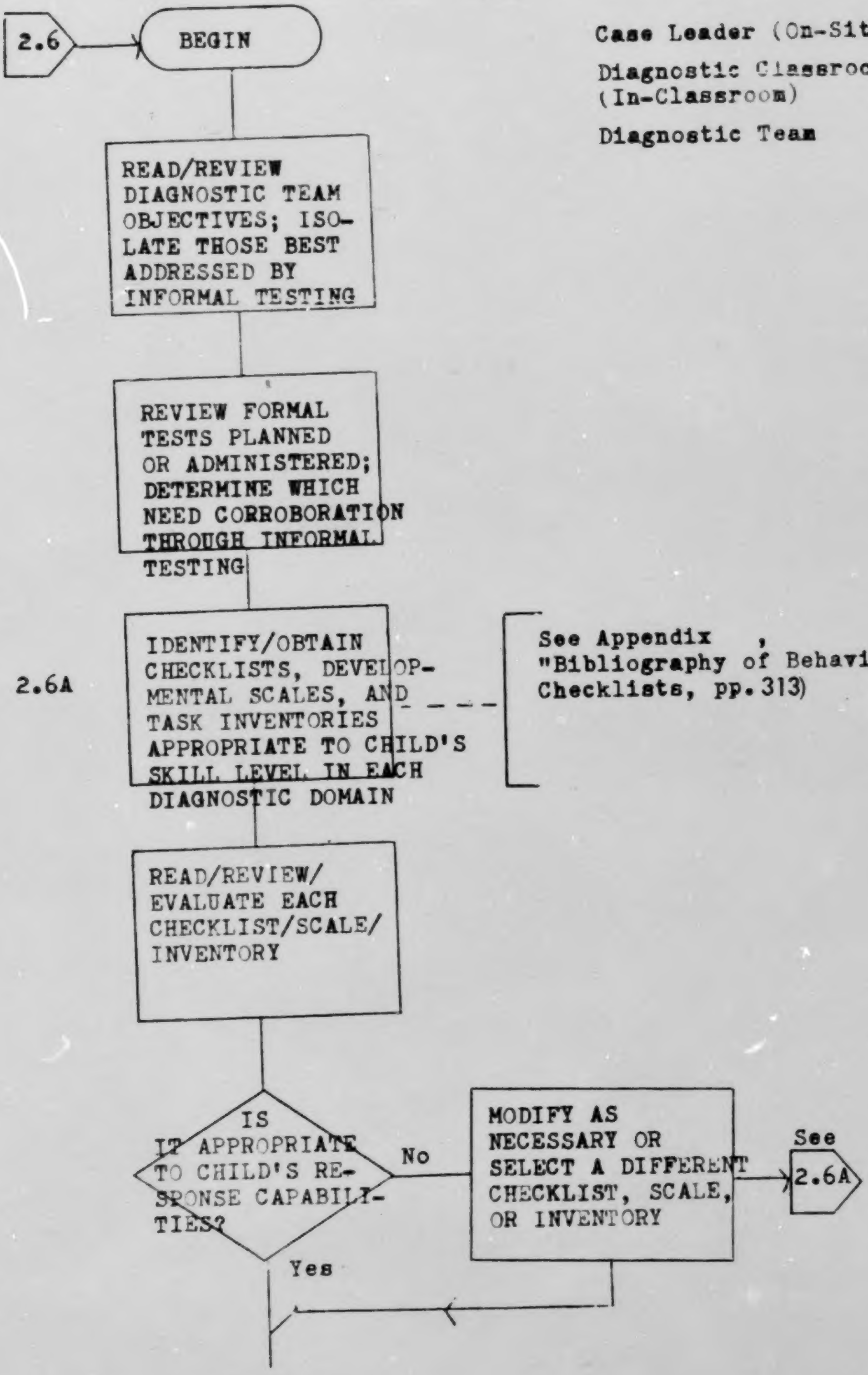

2.6
BEGIN
READ/REVIEW DIAGNOSTIC TEAM OBJECTIVES; ISOLATE THOSE BEST ADDRESSED BY INFORMAL TESTING
REVIEW FORMAL TESTS PLANNED OR ADMINISTERED; DETERMINE WHICH NEED CORROBORATION THROUGH INFORMAL TESTING
2.6A
IDENTIFY/OBTAIN CHECKLISTS, DEVELOPMENTAL SCALES, AND TASK INVENTORIES APPROPRIATE TO CHILD'S SKILL LEVEL IN EACH DIAGNOSTIC DOMAIN
See Appendix , "Bibliography of Behavioral Checklists, pp. 313)
READ/REVIEW/ EVALUATE EACH CHECKLIST/SCALE/ INVENTORY
IS IT APPROPRIATE TO CHILD'S RESPONSE CAPABILITIES?
No
MODIFY AS NECESSARY OR SELECT A DIFFERENT CHECKLIST, SCALE, OR INVENTORY
See
2.6A
Yes

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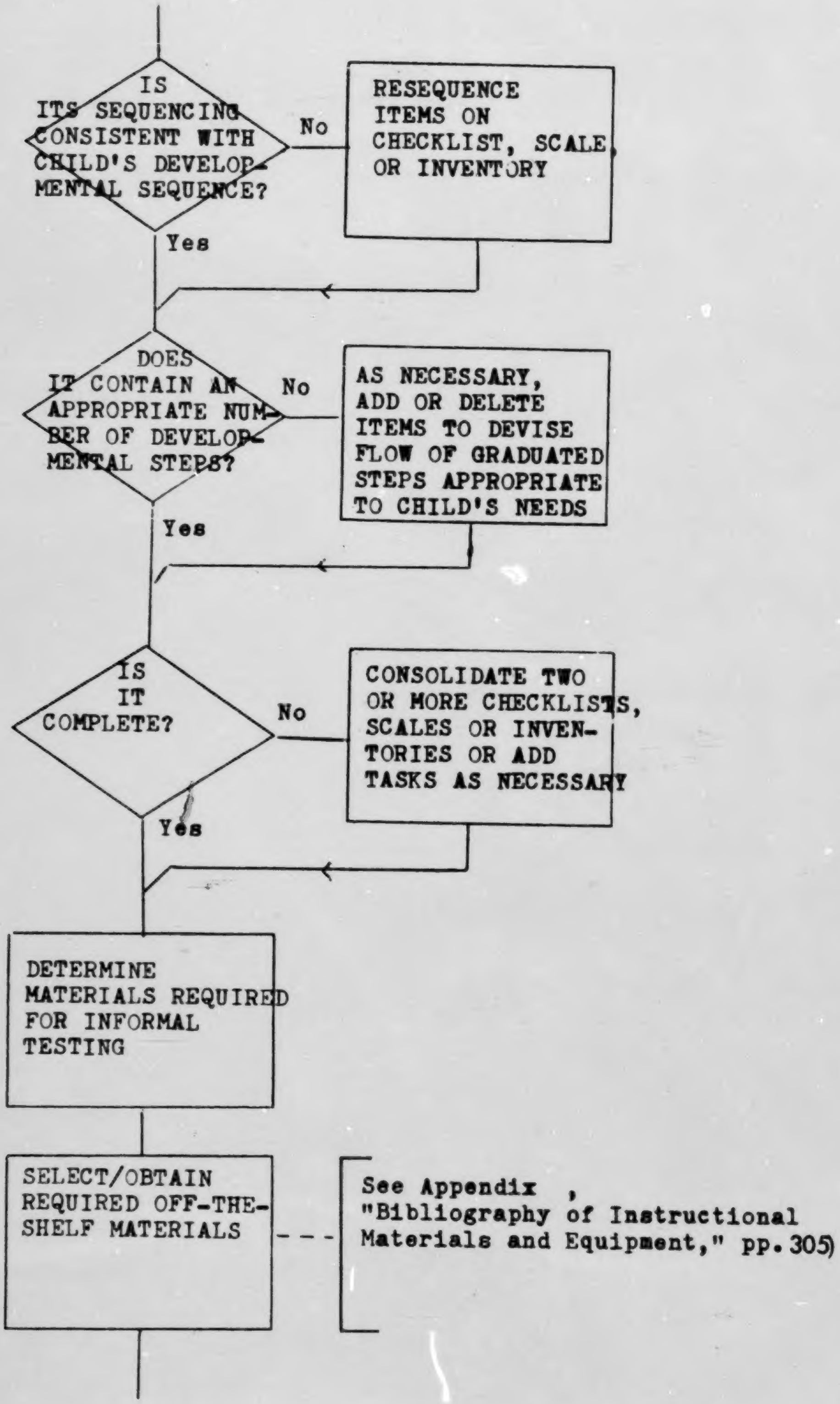
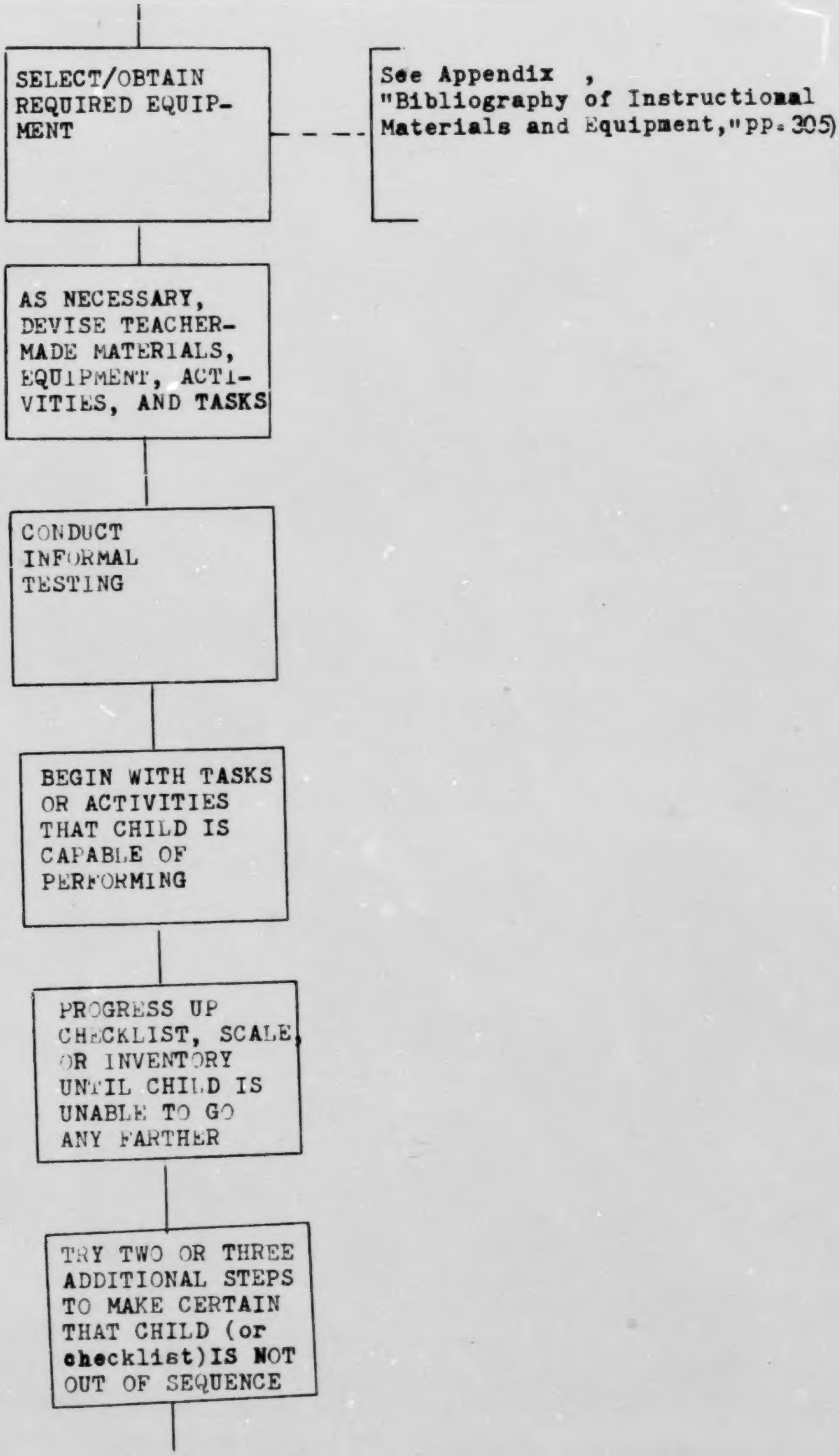
Chart 2.6 Continued


IS ITS SEQUENCING CONSISTENT WITH CHILD'S DEVELOPMENTAL SEQUENCE?
No
RESEQUENCE ITEMS ON CHECKLIST, SCALE, OR INVENTORY
Yes
DOES IT CONTAIN AN APPROPRIATE NUMBER OF DEVELOPMENTAL STEPS?
No
AS NECESSARY, ADD OR DELETE ITEMS TO DEVISE FLOW OF GRADUATED STEPS APPROPRIATE TO CHILD'S NEEDS
Yes
IS IT COMPLETE?
No
CONSOLIDATE TWO OR MORE CHECKLISTS, SCALES OR INVENTORIES OR ADD TASKS AS NECESSARY
Yes
DETERMINE MATERIALS REQUIRED FOR INFORMAL TESTING
SELECT/OBTAIN REQUIRED OFF-THE-SHELF MATERIALS

See Appendix , "Bibliography of Instructional Materials and Equipment," pp. 305)

Continued on next page

Chart 2.6 Continued


SELECT/OBTAIN REQUIRED EQUIPMENT
See Appendix , "Bibliography of Instructional Materials and Equipment," pp. 305)
AS NECESSARY, DEVISE TEACHER-MADE MATERIALS, EQUIPMENT, ACTIVITIES, AND TASKS
CONDUCT INFORMAL TESTING
BEGIN WITH TASKS OR ACTIVITIES THAT CHILD IS CAPABLE OF PERFORMING
PROGRESS UP CHECKLIST, SCALE, OR INVENTORY UNTIL CHILD IS UNABLE TO GO ANY FARTHER
TRY TWO OR THREE ADDITIONAL STEPS TO MAKE CERTAIN THAT CHILD (or checklist) IS NOT OUT OF SEQUENCE

Continued on next page

Chart 2.6 Continued

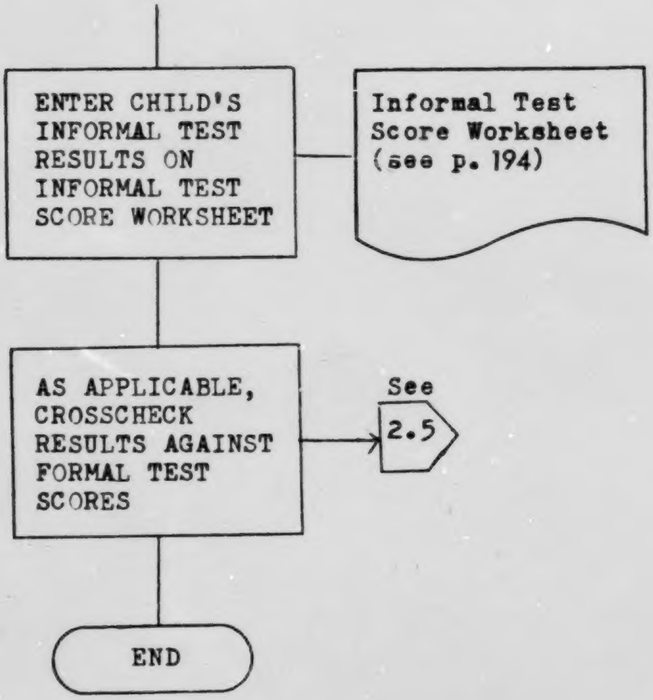
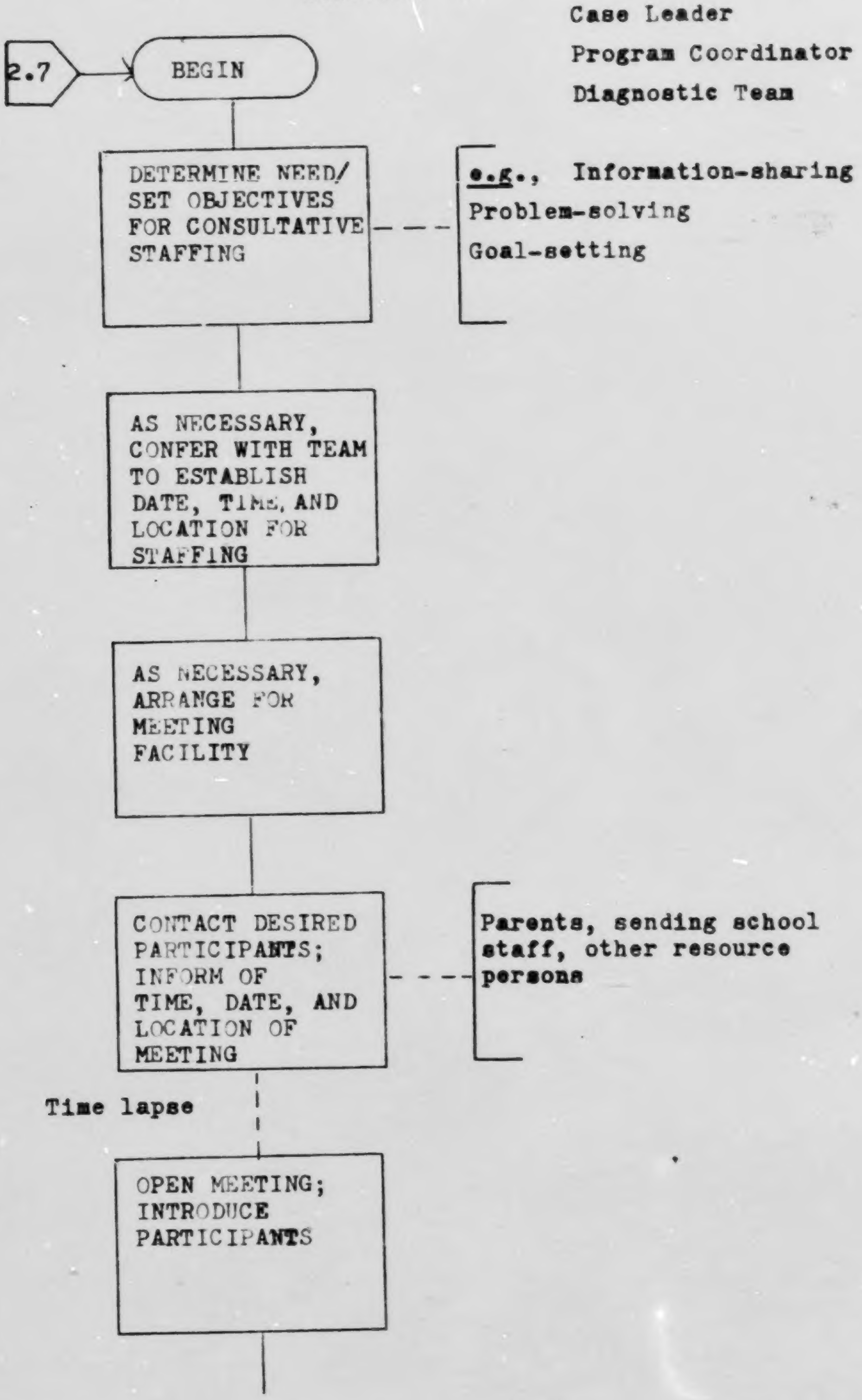
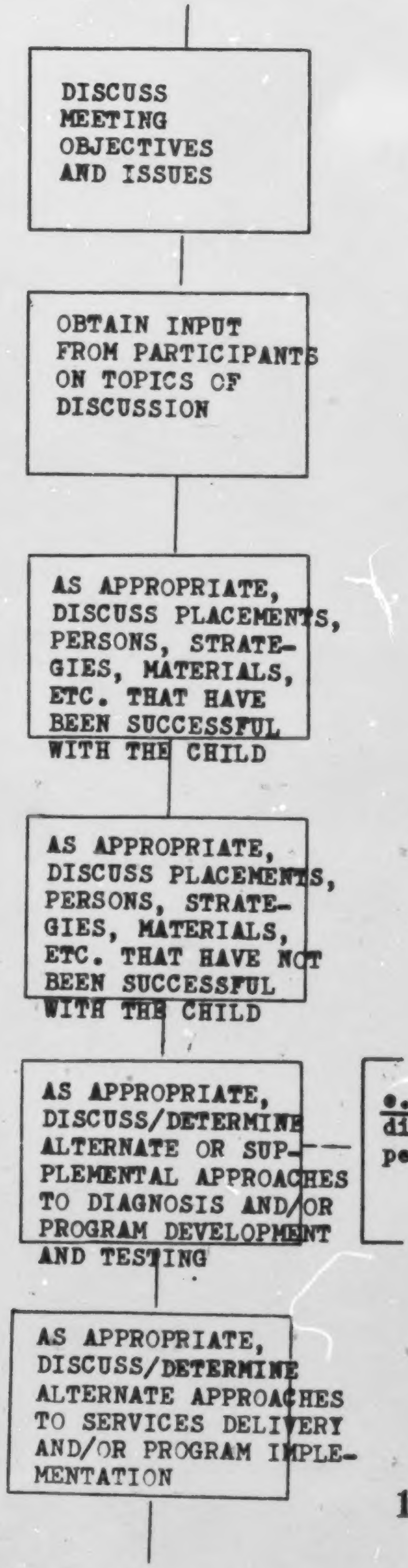

ENTER CHILD'S INFORMAL TEST RESULTS ON INFORMAL TEST SCORE WORKSHEET
Informal Test Score Worksheet (see p. 194)
AS APPLICABLE, CROSSCHECK RESULTS AGAINST FORMAL TEST SCORES
See
2.5
END

Chart 2.7 PLAN/CONDUCT/PARTICIPATE IN FORMAL OR INFORMAL CONSULTATIVE STAFFING


Case Leader
Program Coordinator
Diagnostic Team
2.7
BEGIN
DETERMINE NEED/ SET OBJECTIVES FOR CONSULTATIVE STAFFING
e.g., Information-sharing
Problem-solving
Goal-setting
AS NECESSARY, CONFER WITH TEAM TO ESTABLISH DATE, TIME, AND LOCATION FOR STAFFING
AS NECESSARY, ARRANGE FOR MEETING FACILITY
CONTACT DESIRED PARTICIPANTS; INFORM OF TIME, DATE, AND LOCATION OF MEETING
Parents, sending school staff, other resource persons
Time lapse
OPEN MEETING; INTRODUCE PARTICIPANTS

Continued on next page

Chart 2.7 Continued

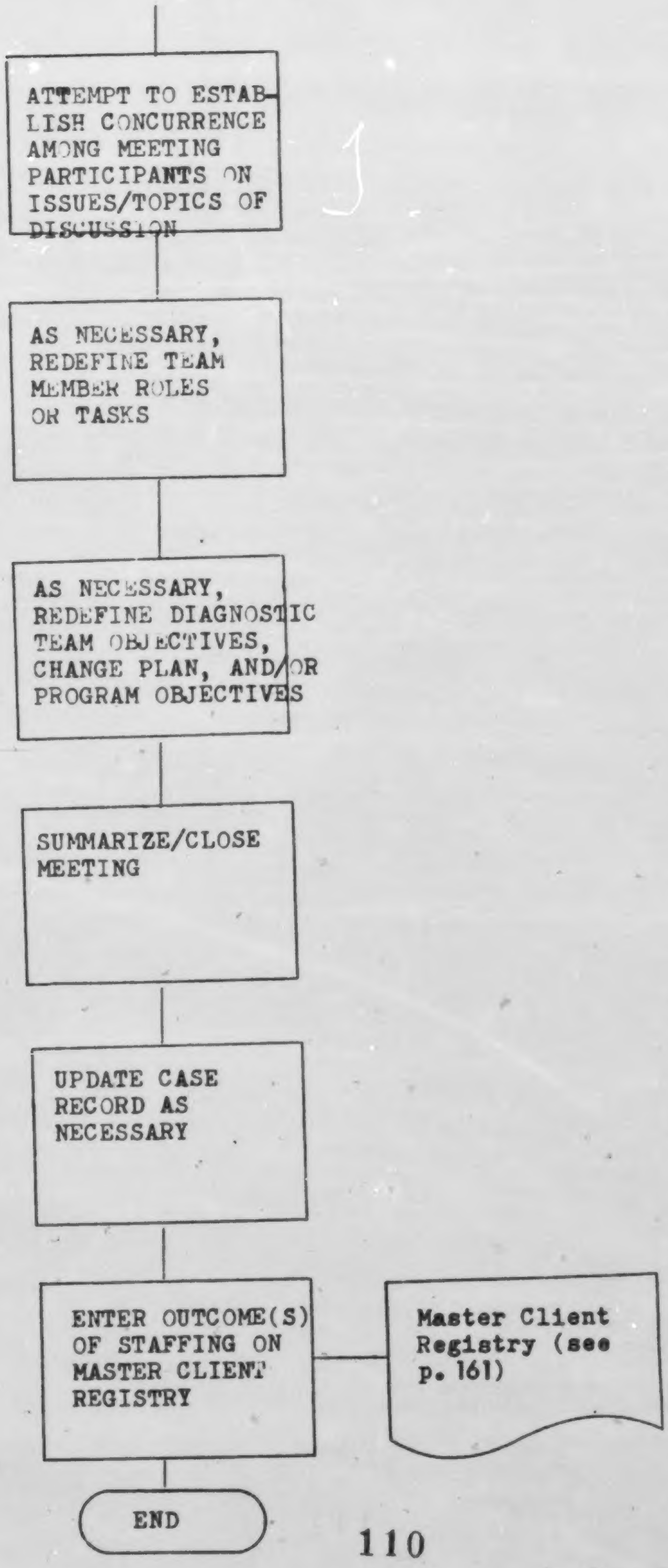

DISCUSS MEETING OBJECTIVES AND ISSUES
OBTAIN INPUT FROM PARTICIPANTS ON TOPICS OF DISCUSSION
AS APPROPRIATE, DISCUSS PLACEMENTS, PERSONS, STRATEGIES, MATERIALS, ETC. THAT HAVE BEEN SUCCESSFUL WITH THE CHILD
AS APPROPRIATE, DISCUSS PLACEMENTS, PERSONS, STRATEGIES, MATERIALS, ETC. THAT HAVE NOT BEEN SUCCESSFUL WITH THE CHILD
AS APPROPRIATE, DISCUSS/DETERMINE ALTERNATE OR SUPPLEMENTAL APPROACHES TO DIAGNOSIS AND/OR PROGRAM DEVELOPMENT AND TESTING
AS APPROPRIATE, DISCUSS/DETERMINE ALTERNATE APPROACHES TO SERVICES DELIVERY AND/OR PROGRAM IMPLEMENTATION

e.g., alternative placements, materials, diagnostic tests, activities, equipment, personnel, physical settings, etc.

Continued on next page

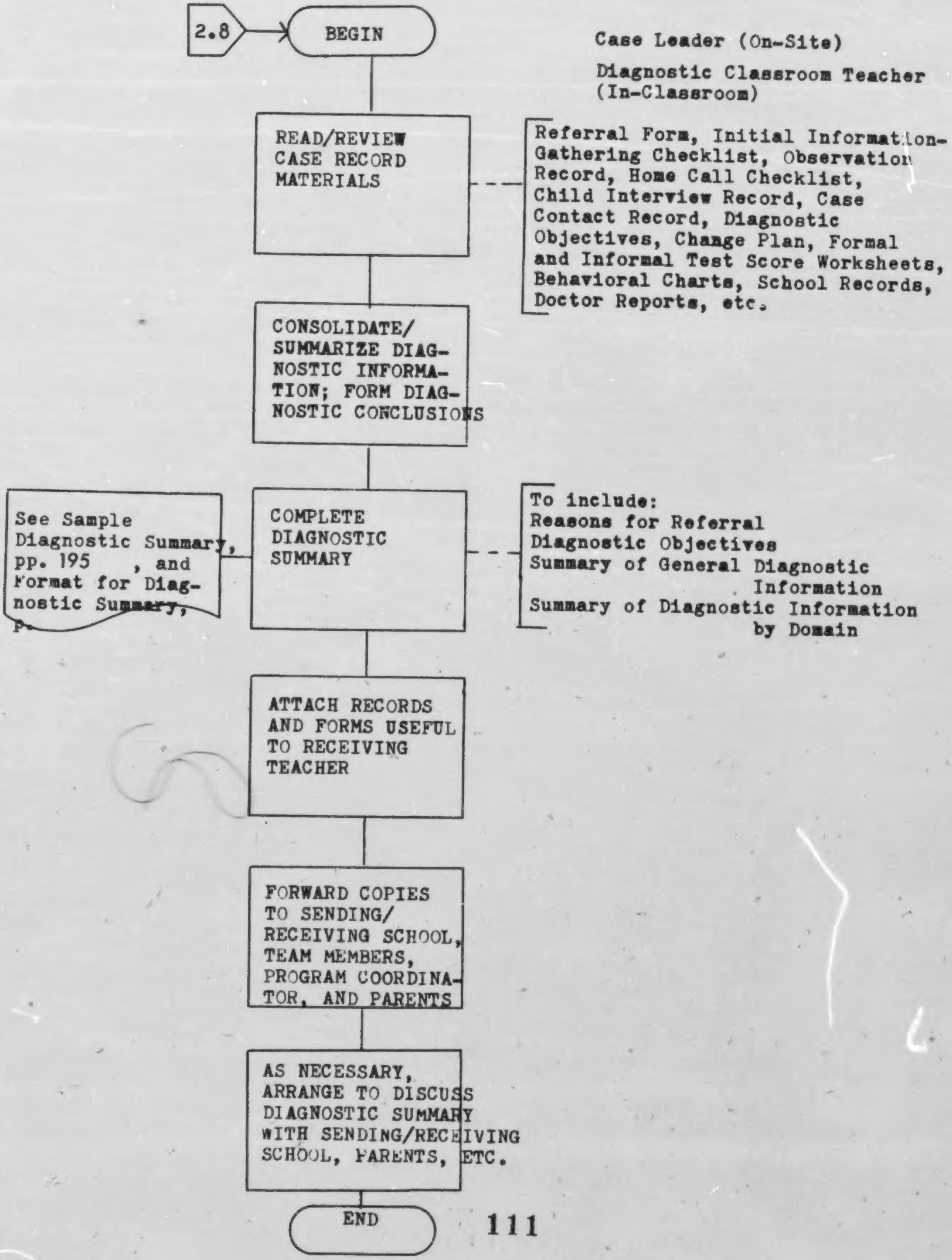
Page two of three

Chart 2.7 Continued


ATTEMPT TO ESTABLISH CONCURRENCE AMONG MEETING PARTICIPANTS ON ISSUES/TOPICS OF DISCUSSION
AS NECESSARY, REDEFINE TEAM MEMBER ROLES OR TASKS
AS NECESSARY, REDEFINE DIAGNOSTIC TEAM OBJECTIVES, CHANGE PLAN, AND/OR PROGRAM OBJECTIVES
SUMMARIZE/CLOSE MEETING
UPDATE CASE RECORD AS NECESSARY
ENTER OUTCOME(S) OF STAFFING ON MASTER CLIENT REGISTRY
Master Client Registry (see p. 161)
END

Page three of three

Chart 2.8 COMPLETE DIAGNOSTIC SUMMARY


2.8
BEGIN
READ/REVIEW CASE RECORD MATERIALS
CONSOLIDATE/ SUMMARIZE DIAGNOSTIC INFORMATION; FORM DIAGNOSTIC CONCLUSIONS
COMPLETE DIAGNOSTIC SUMMARY
ATTACH RECORDS AND FORMS USEFUL TO RECEIVING TEACHER
FORWARD COPIES TO SENDING/ RECEIVING SCHOOL, TEAM MEMBERS, PROGRAM COORDINATOR, AND PARENTS
AS NECESSARY, ARRANGE TO DISCUSS DIAGNOSTIC SUMMARY WITH SENDING/RECEIVING SCHOOL, PARENTS, ETC.
END

Case Leader (On-Site)

Diagnostic Classroom Teacher (In-Classroom)

Referral Form, Initial Information-Gathering Checklist, Observation Record, Home Call Checklist, Child Interview Record, Case Contact Record, Diagnostic Objectives, Change Plan, Formal and Informal Test Score Worksheets, Behavioral Charts, School Records, Doctor Reports, etc.

See Sample Diagnostic Summary, pp. 195 , and Format for Diagnostic Summary, p.

To include:
Reasons for Referral
Diagnostic Objectives
Summary of General Diagnostic Information
Summary of Diagnostic Information by Domain

Phase 3: PROGRAM DEVELOPMENT AND TESTING

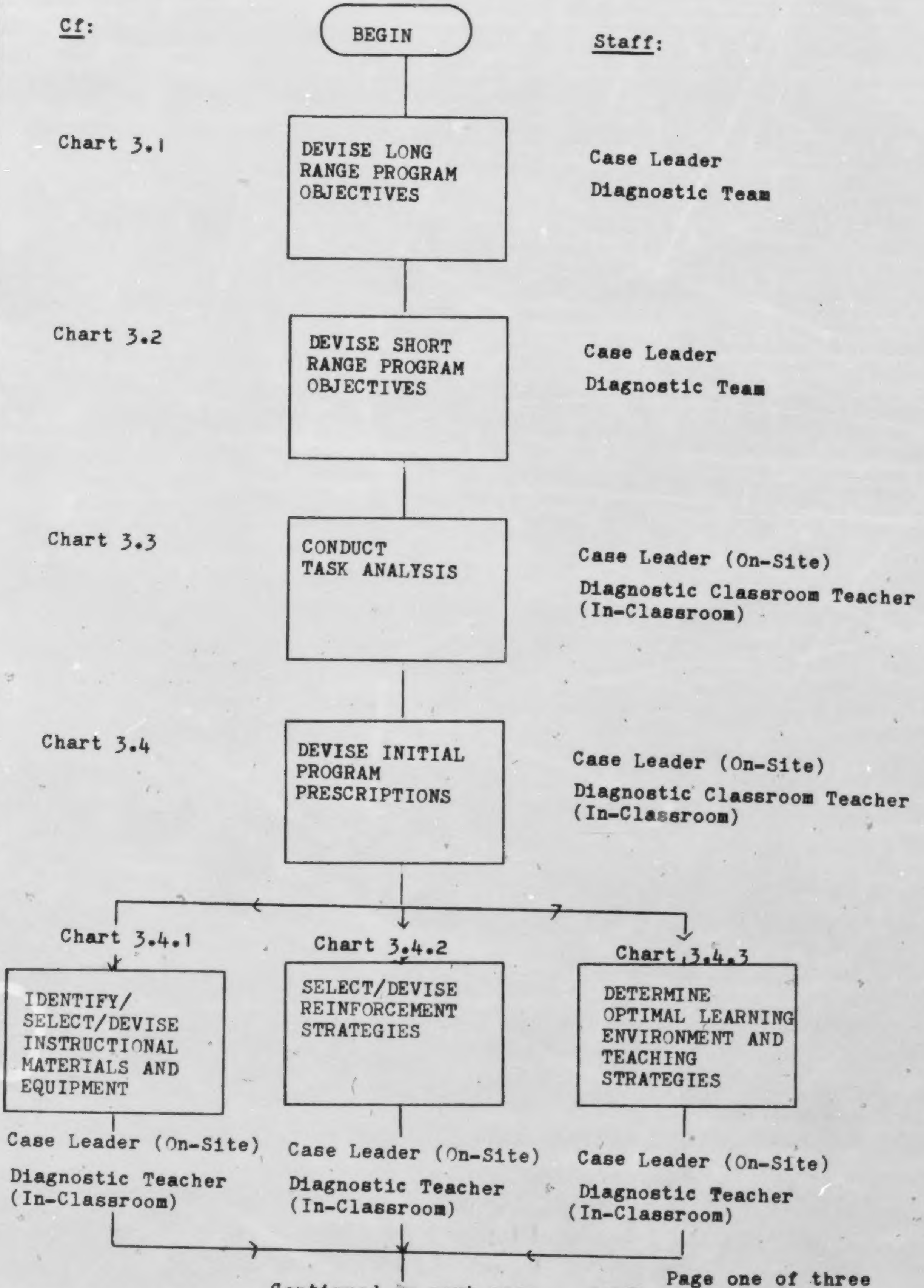
Objectives:

1. To establish long and short range program objectives.
2. To devise, test, modify, retest, and finalize program prescriptions.
3. To devise placement recommendations and follow-up plans.

Initiating Event: Formation of Program Objectives

Terminating Event: Completion of Individual Educational Plan

OVERVIEW OF PHASE 3: PROGRAM DEVELOPMENT AND TESTING


Cf:
BEGIN
Staff:
Chart 3.1
DEVISE LONG RANGE PROGRAM OBJECTIVES
Case Leader
Diagnostic Team
Chart 3.2
DEVISE SHORT RANGE PROGRAM OBJECTIVES
Case Leader
Diagnostic Team
Chart 3.3
CONDUCT TASK ANALYSIS
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Chart 3.4
DEVISE INITIAL PROGRAM PRESCRIPTIONS
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Chart 3.4.1
IDENTIFY/ SELECT/DEVISE INSTRUCTIONAL MATERIALS AND EQUIPMENT
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)
Chart 3.4.2
SELECT/DEVISE REINFORCEMENT STRATEGIES
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)
Chart 3.4.3
DETERMINE OPTIMAL LEARNING ENVIRONMENT AND TEACHING STRATEGIES
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)

Continued on next page

Page one of three

Phase 3 Overview Chart, Continued

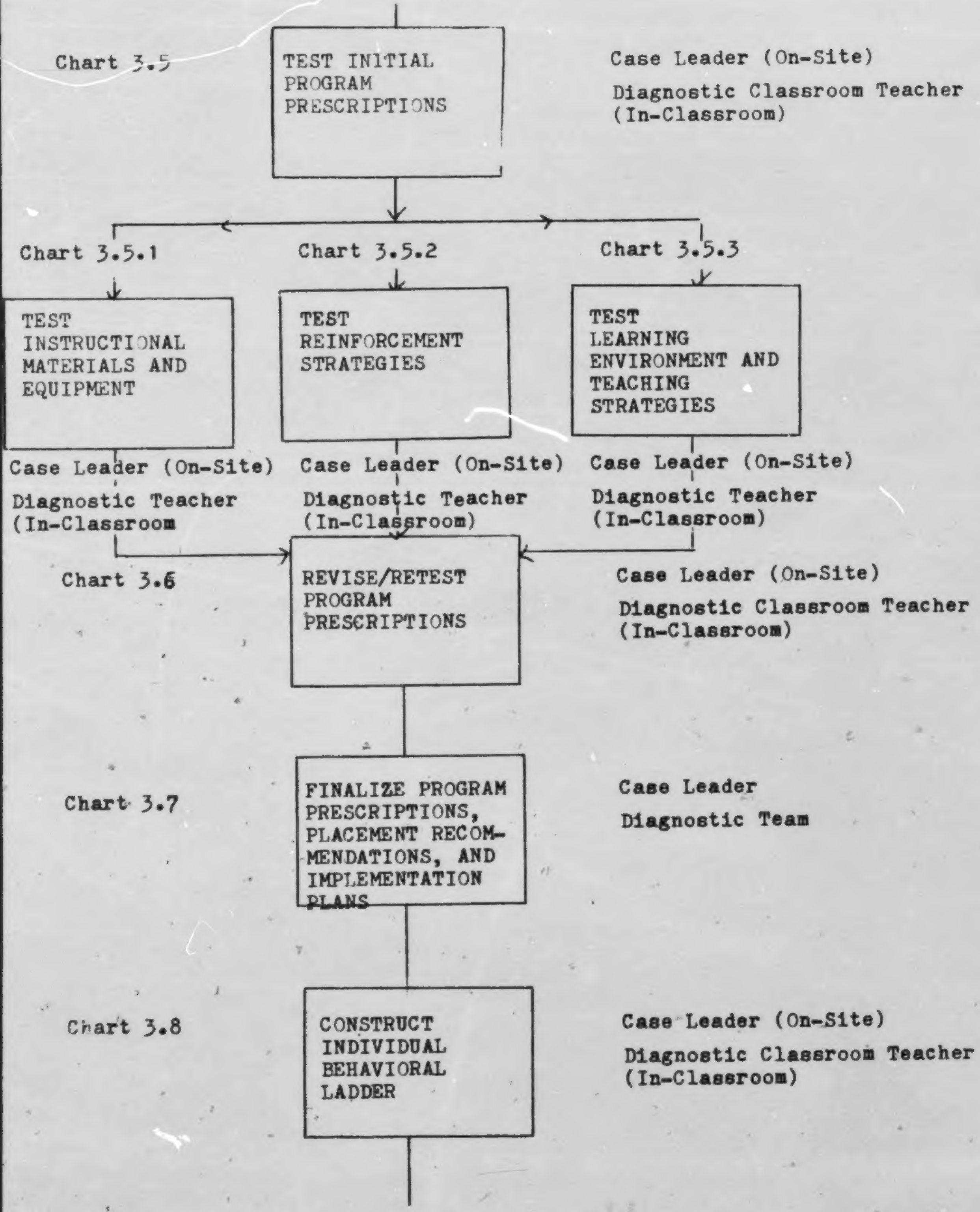


Chart 3.5
TEST INITIAL PROGRAM PRESCRIPTIONS
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Chart 3.5.1
TEST INSTRUCTIONAL MATERIALS AND EQUIPMENT
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom
Chart 3.5.2
TEST REINFORCEMENT STRATEGIES
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)
Chart 3.5.3
TEST LEARNING ENVIRONMENT AND TEACHING STRATEGIES
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)
Chart 3.6
REVISE/RETEST PROGRAM PRESCRIPTIONS
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Chart 3.7
FINALIZE PROGRAM PRESCRIPTIONS, PLACEMENT RECOMMENDATIONS, AND IMPLEMENTATION PLANS
Case Leader
Diagnostic Team
Chart 3.8
CONSTRUCT INDIVIDUAL BEHAVIORAL LADDER
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

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Phase 3 Overview Chart, Continued

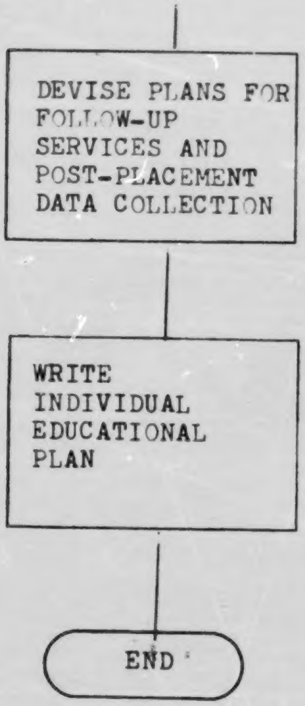

DEVISE PLANS FOR FOLLOW-UP SERVICES AND POST-PLACEMENT DATA COLLECTION
WRITE INDIVIDUAL EDUCATIONAL PLAN
END

Chart 3.9

Case Leader

Diagnostic Team

Chart 3.10

Case Leader (On-Site)

Diagnostic Classroom Teacher (In-Classroom)

Chart 3.1 DEVISE LONG-RANGE PROGRAM OBJECTIVES

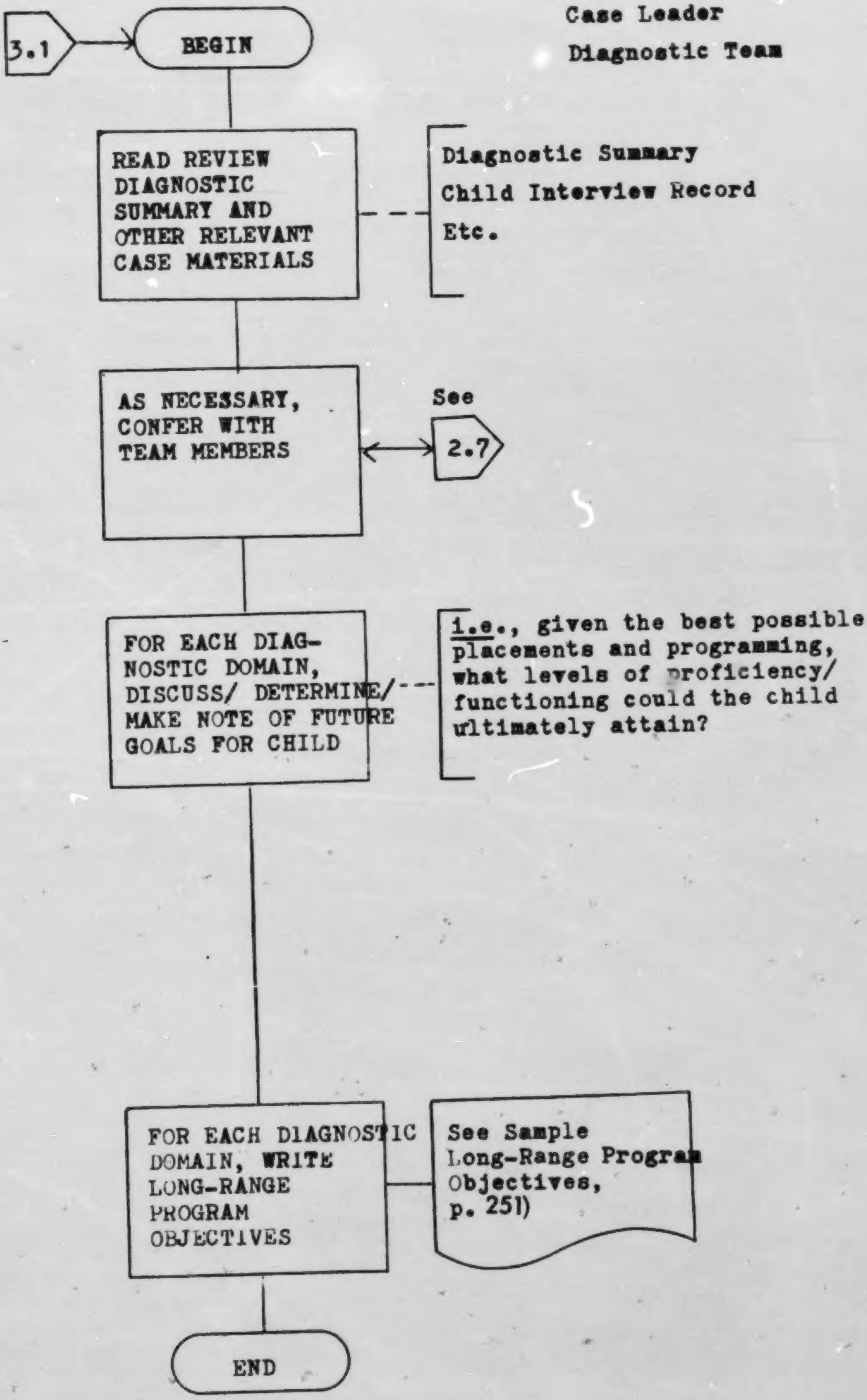
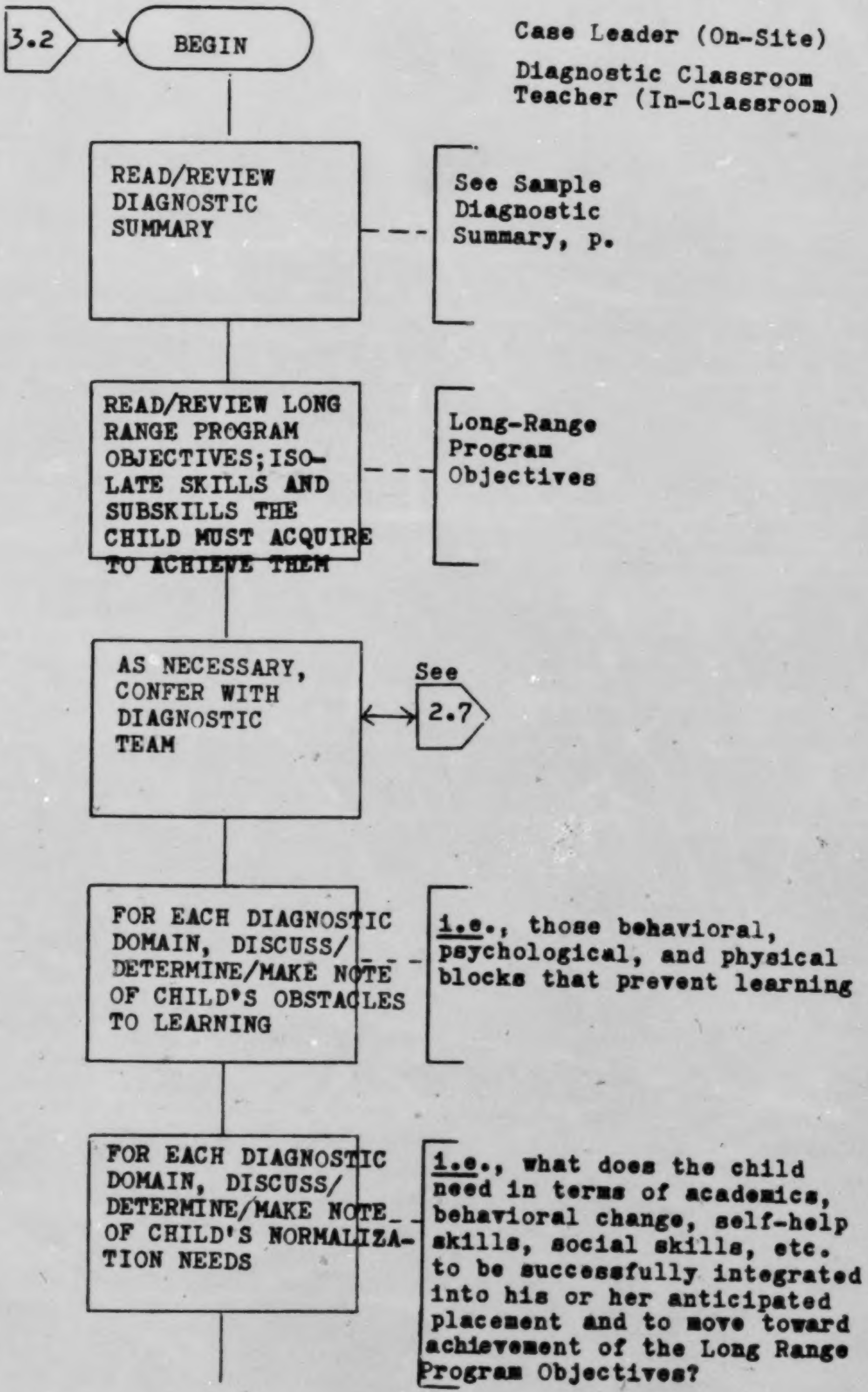
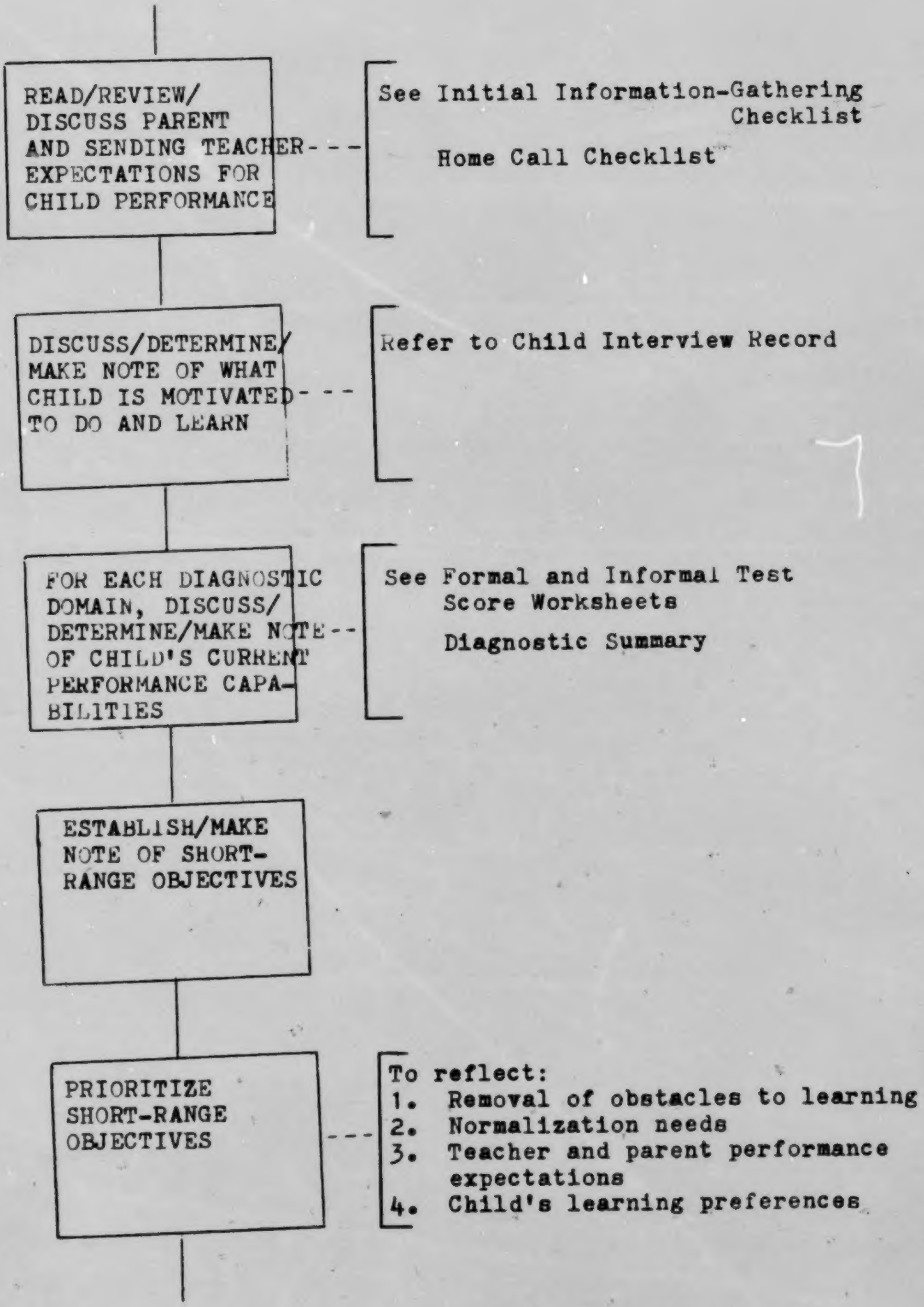

Case Leader
Diagnostic Team
3.1
BEGIN
READ REVIEW DIAGNOSTIC SUMMARY AND OTHER RELEVANT CASE MATERIALS
Diagnostic Summary
Child Interview Record
Etc.
AS NECESSARY, CONFER WITH TEAM MEMBERS
See
2.7
FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/ DETERMINE/ MAKE NOTE OF FUTURE GOALS FOR CHILD
i.e., given the best possible placements and programming, what levels of proficiency/ functioning could the child ultimately attain?
FOR EACH DIAGNOSTIC DOMAIN, WRITE LONG-RANGE PROGRAM OBJECTIVES
See Sample Long-Range Program Objectives, p. 251)
END

Chart 3.2 DEVISE/PRIORITIZE/SEQUENCE SHORT RANGE PROGRAM OBJECTIVES


3.2
BEGIN
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
READ/REVIEW DIAGNOSTIC SUMMARY
See Sample Diagnostic Summary, p.
READ/REVIEW LONG RANGE PROGRAM OBJECTIVES; ISOLATE SKILLS AND SUBSKILLS THE CHILD MUST ACQUIRE TO ACHIEVE THEM
Long-Range Program Objectives
AS NECESSARY, CONFER WITH DIAGNOSTIC TEAM
See
2.7
FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S OBSTACLES TO LEARNING
i.e., those behavioral, psychological, and physical blocks that prevent learning
FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S NORMALIZATION NEEDS
i.e., what does the child need in terms of academics, behavioral change, self-help skills, social skills, etc. to be successfully integrated into his or her anticipated placement and to move toward achievement of the Long Range Program Objectives?

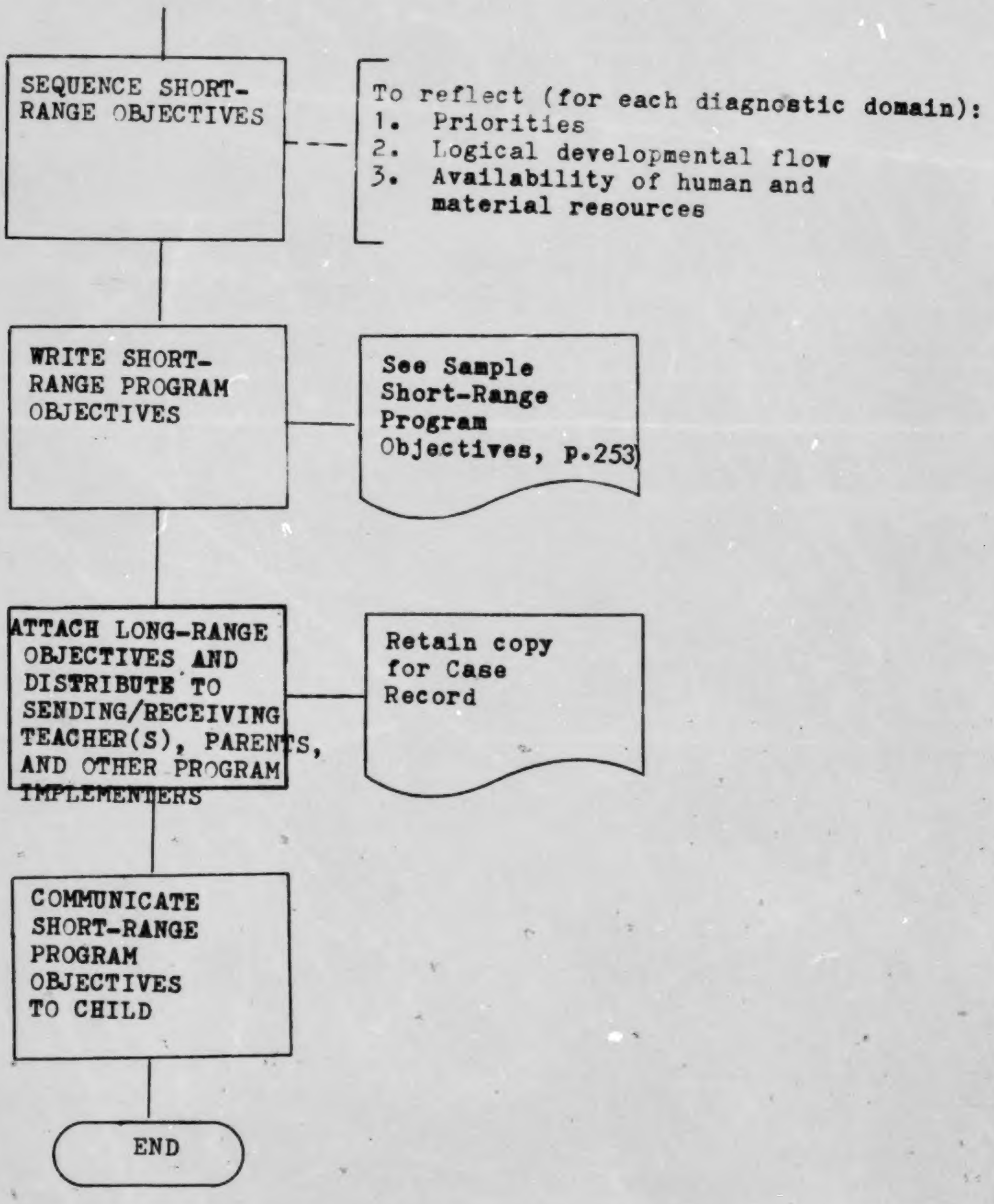
Continued on next page

Chart 3.2 Continued


READ/REVIEW/ DISCUSS PARENT AND SENDING TEACHER EXPECTATIONS FOR CHILD PERFORMANCE
See Initial Information-Gathering Checklist
Home Call Checklist
DISCUSS/DETERMINE/ MAKE NOTE OF WHAT CHILD IS MOTIVATED TO DO AND LEARN
Refer to Child Interview Record
FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/ DETERMINE/MAKE NOTE OF CHILD'S CURRENT PERFORMANCE CAPABILITIES
See Formal and Informal Test Score Worksheets
Diagnostic Summary
ESTABLISH/MAKE NOTE OF SHORT-RANGE OBJECTIVES
PRIORITIZE SHORT-RANGE OBJECTIVES
To reflect:
1. Removal of obstacles to learning
2. Normalization needs
3. Teacher and parent performance expectations
4. Child's learning preferences

Continued on next page

Chart 3.2 Continued

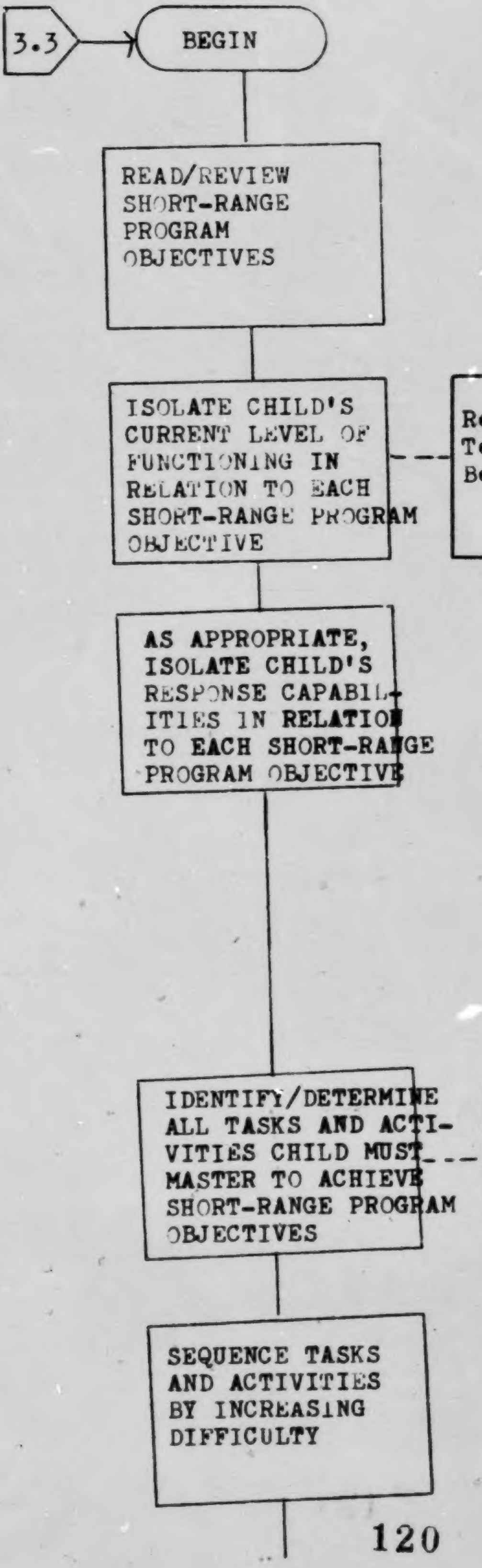

SEQUENCE SHORT-RANGE OBJECTIVES
To reflect (for each diagnostic domain):
1. Priorities
2. Logical developmental flow
3. Availability of human and material resources
WRITE SHORT-RANGE PROGRAM OBJECTIVES
See Sample Short-Range Program Objectives, p.253
ATTACH LONG-RANGE OBJECTIVES AND DISTRIBUTE TO SENDING/RECEIVING TEACHER(S), PARENTS, AND OTHER PROGRAM IMPLEMENTERS
Retain copy for Case Record
COMMUNICATE SHORT-RANGE PROGRAM OBJECTIVES TO CHILD
END

Page three of three

Chart 3.3 CONDUCT TASK ANALYSIS

Case Leader (On-Site)

Diagnostic Classroom Teacher (In-Classroom)


3.3
BEGIN
READ/REVIEW SHORT-RANGE PROGRAM OBJECTIVES
ISOLATE CHILD'S CURRENT LEVEL OF FUNCTIONING IN RELATION TO EACH SHORT-RANGE PROGRAM OBJECTIVE
AS APPROPRIATE, ISOLATE CHILD'S RESPONSE CAPABILITIES IN RELATION TO EACH SHORT-RANGE PROGRAM OBJECTIVE
IDENTIFY/DETERMINE ALL TASKS AND ACTIVITIES CHILD MUST MASTER TO ACHIEVE SHORT-RANGE PROGRAM OBJECTIVES
SEQUENCE TASKS AND ACTIVITIES BY INCREASING DIFFICULTY

Refer to Formal and Informal Test Score Worksheets and Behavioral Charts

As necessary, employ behavioral checklists, developmental scales, activity guides, task inventories, etc. (See Appendix , "Bibliography of Behavioral Checklists", pp. 313)

Continued on next page

Chart 3.3 Continued

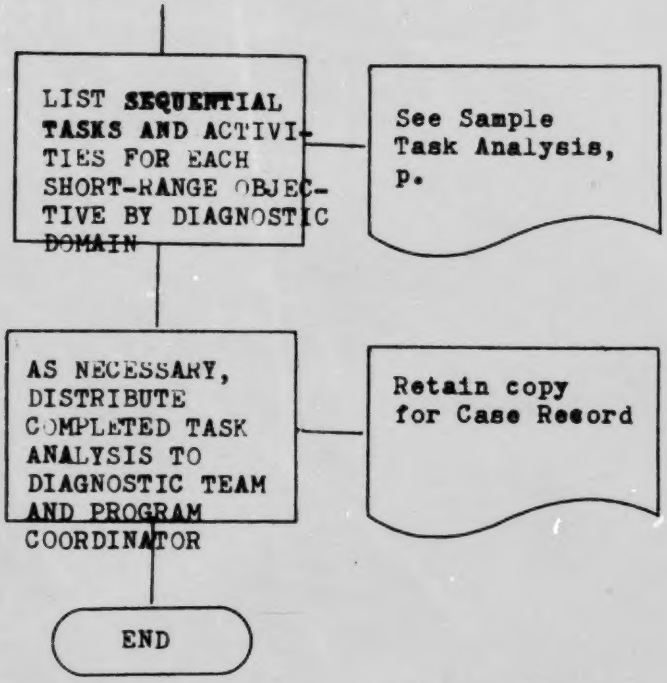

LIST SEQUENTIAL TASKS AND ACTIVITIES FOR EACH SHORT-RANGE OBJECTIVE BY DIAGNOSTIC DOMAIN
See Sample Task Analysis, p.
AS NECESSARY, DISTRIBUTE COMPLETED TASK ANALYSIS TO DIAGNOSTIC TEAM AND PROGRAM COORDINATOR
Retain copy for Case Record
END

Chart 3.4 DEVISE INITIAL PROGRAM PRESCRIPTIONS

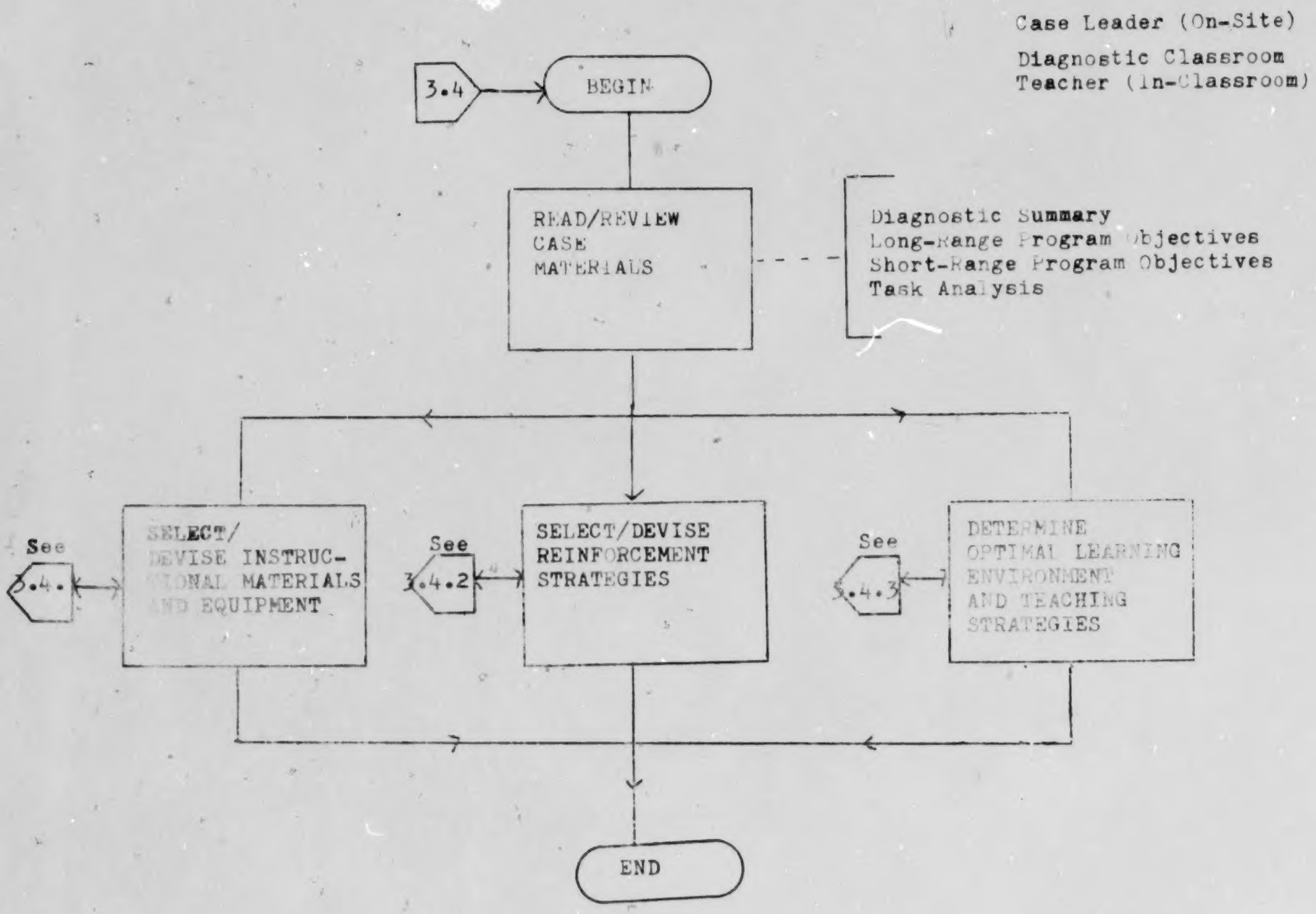
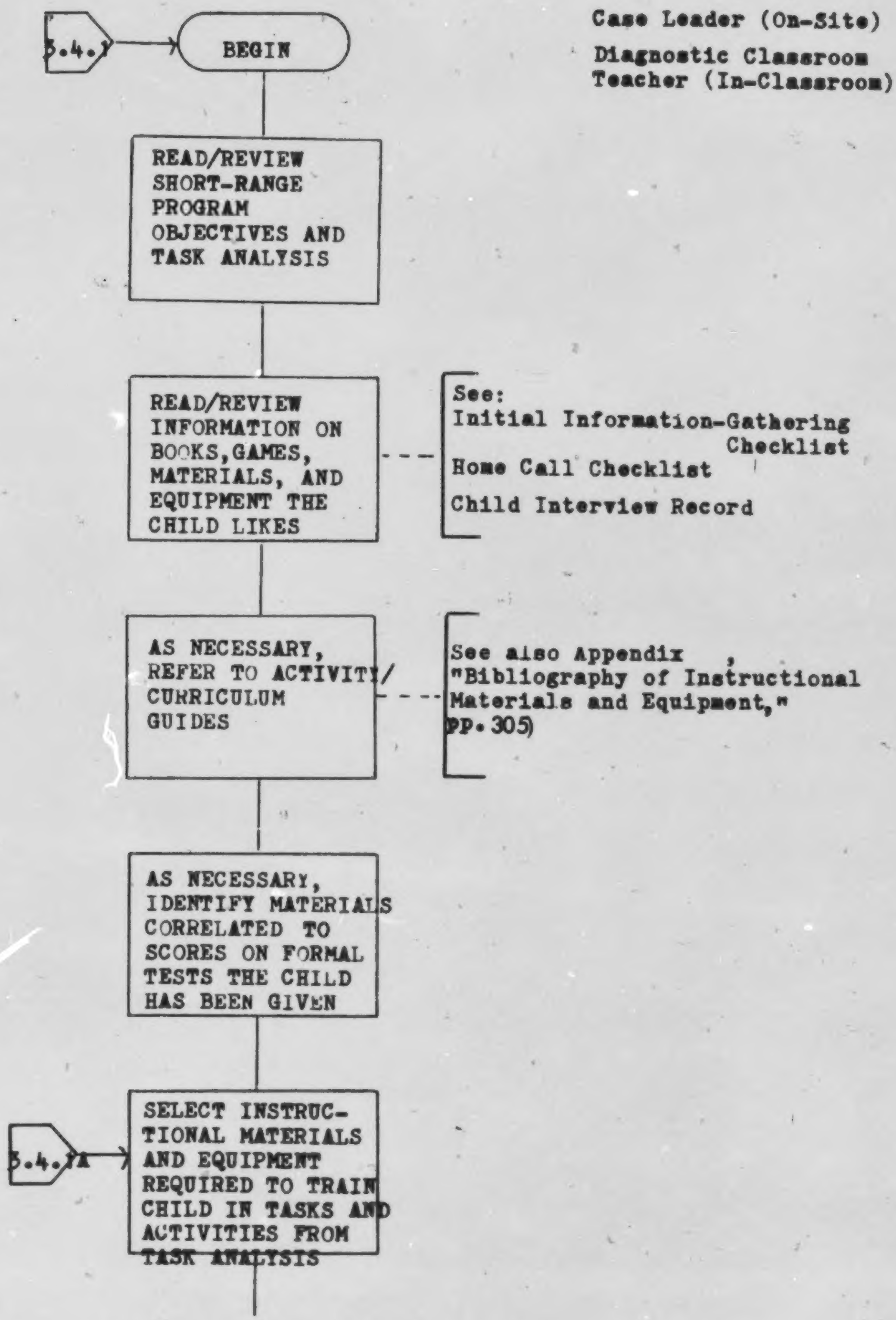
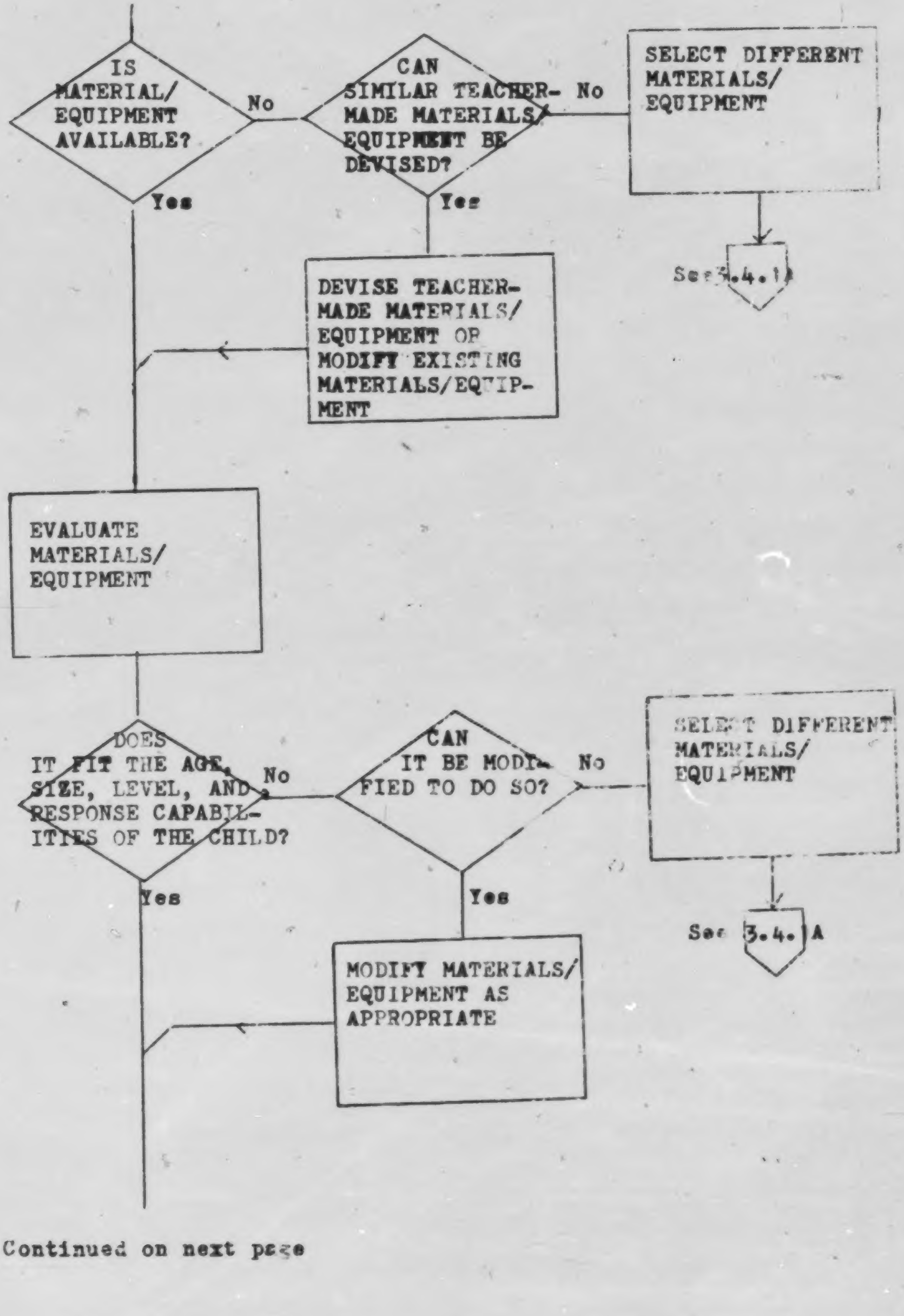

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
3.4
BEGIN
READ/REVIEW CASE MATERIALS
Diagnostic Summary
Long-Range Program Objectives
Short-Range Program Objectives
Task Analysis
See
3.4.
SELECT/DEVISE INSTRUCTIONAL MATERIALS AND EQUIPMENT
See
3.4.2
SELECT/DEVISE REINFORCEMENT STRATEGIES
See
3.4.3
DETERMINE OPTIMAL LEARNING ENVIRONMENT AND TEACHING STRATEGIES
END

Chart 3.4.1 IDENTIFY/SELECT/DEVISE INSTRUCTIONAL MATERIALS AND EQUIPMENT


Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
3.4.1
BEGIN
READ/REVIEW SHORT-RANGE PROGRAM OBJECTIVES AND TASK ANALYSIS
READ/REVIEW INFORMATION ON BOOKS, GAMES, MATERIALS, AND EQUIPMENT THE CHILD LIKES
See:
Initial Information-Gathering Checklist
Home Call Checklist
Child Interview Record
AS NECESSARY, REFER TO ACTIVITY/ CURRICULUM GUIDES
See also Appendix , "Bibliography of Instructional Materials and Equipment," pp. 305)
AS NECESSARY, IDENTIFY MATERIALS CORRELATED TO SCORES ON FORMAL TESTS THE CHILD HAS BEEN GIVEN
3.4.1A
SELECT INSTRUCTIONAL MATERIALS AND EQUIPMENT REQUIRED TO TRAIN CHILD IN TASKS AND ACTIVITIES FROM TASK ANALYSIS

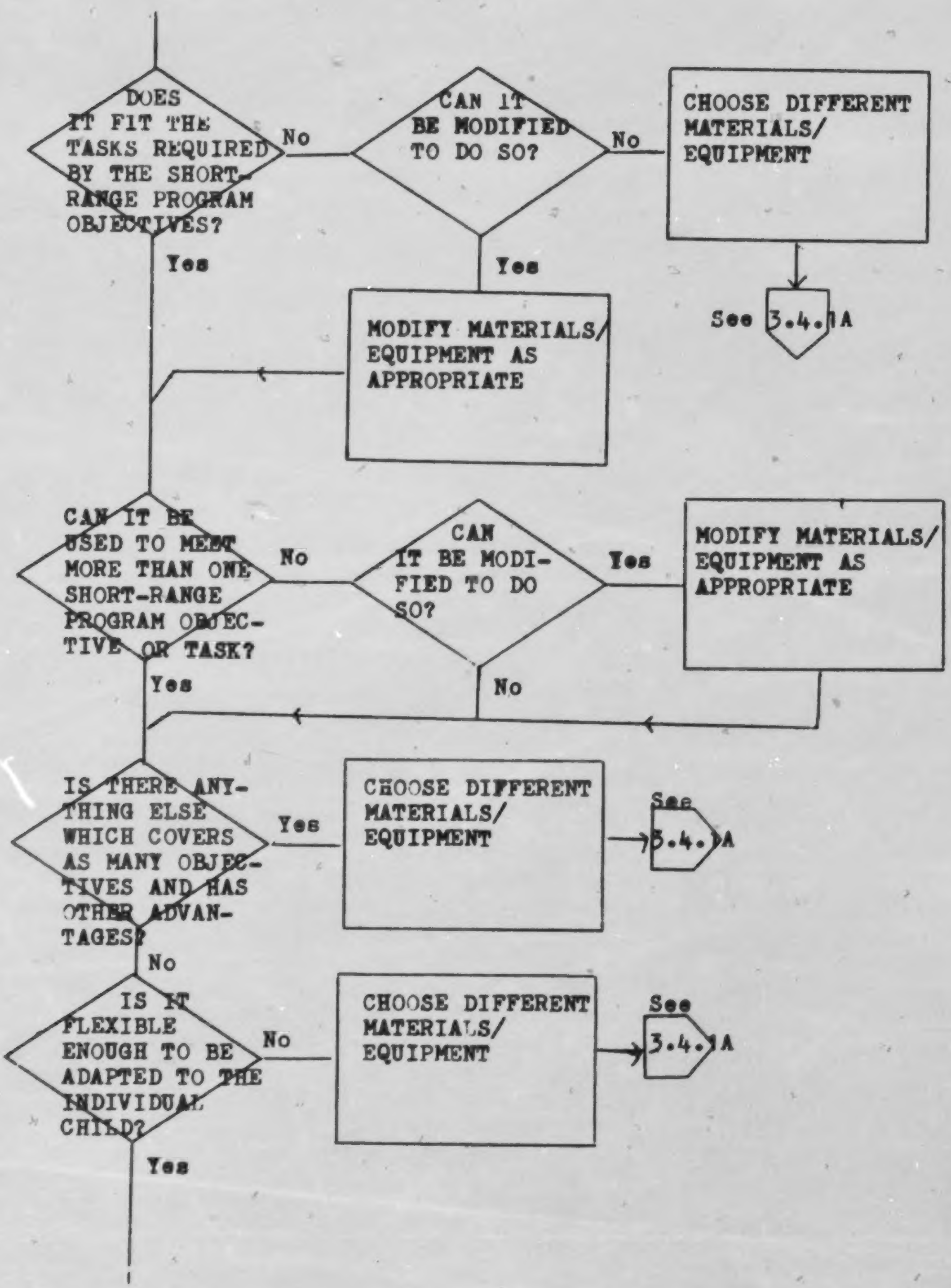
Continued on next page

Chart 3.4.1 Continued


IS MATERIAL/ EQUIPMENT AVAILABLE?
No
Yes
CAN SIMILAR TEACHER-MADE MATERIALS/ EQUIPMENT BE DEVISED?
No
Yes
SELECT DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
DEVISE TEACHER-MADE MATERIALS/ EQUIPMENT OR MODIFY EXISTING MATERIALS/EQUIPMENT
EVALUATE MATERIALS/ EQUIPMENT
DOES IT FIT THE AGE, SIZE, LEVEL, AND RESPONSE CAPABILITIES OF THE CHILD?
No
Yes
CAN IT BE MODIFIED TO DO SO?
No
Yes
SELECT DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
MODIFY MATERIALS/ EQUIPMENT AS APPROPRIATE

Continued on next page

Chart 3.4.1 Continued


DOES IT FIT THE TASKS REQUIRED BY THE SHORT-RANGE PROGRAM OBJECTIVES?
No
CAN IT BE MODIFIED TO DO SO?
No
CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
Yes
Yes
MODIFY MATERIALS/ EQUIPMENT AS APPROPRIATE
CAN IT BE USED TO MEET MORE THAN ONE SHORT-RANGE PROGRAM OBJECTIVE OR TASK?
No
CAN IT BE MODIFIED TO DO SO?
Yes
MODIFY MATERIALS/ EQUIPMENT AS APPROPRIATE
No
Yes
IS THERE ANYTHING ELSE WHICH COVERS AS MANY OBJECTIVES AND HAS OTHER ADVANTAGES?
Yes
CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
No
IS IT FLEXIBLE ENOUGH TO BE ADAPTED TO THE INDIVIDUAL CHILD?
No
CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
Yes

Continued on next page

Chart 3.4.1 Continued

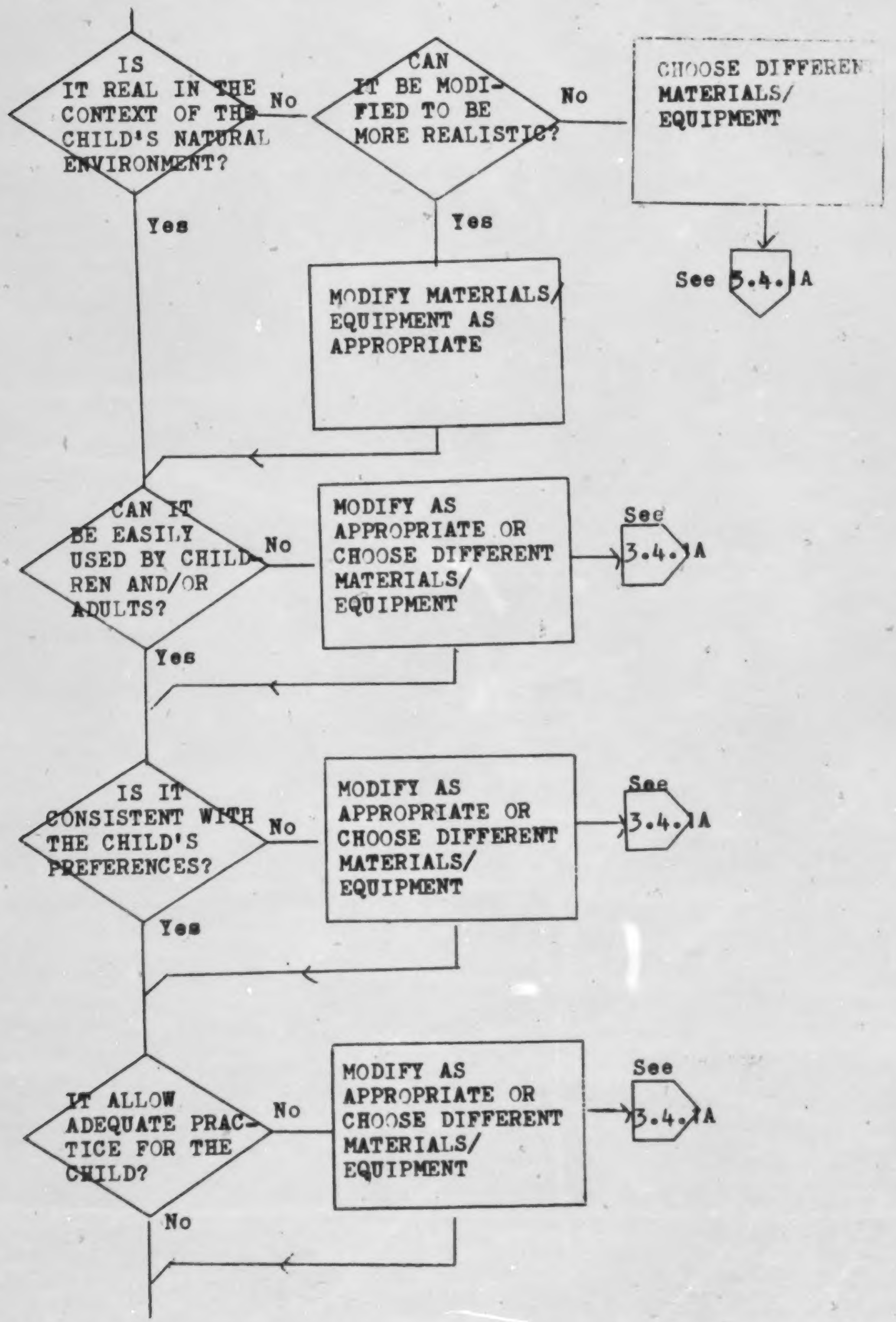

IS IT REAL IN THE CONTEXT OF THE CHILD'S NATURAL ENVIRONMENT?
No
CAN IT BE MODIFIED TO BE MORE REALISTIC?
No
CHOOSE DIFFEREN MATERIALS/ EQUIPMENT
See 3.4.1A
Yes
Yes
MODIFY MATERIALS/ EQUIPMENT AS APPROPRIATE
CAN IT BE EASILY USED BY CHILDREN AND/OR ADULTS?
No
MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
Yes
IS IT CONSISTENT WITH THE CHILD'S PREFERENCES?
No
MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
Yes
IT ALLOW ADEQUATE PRACTICE FOR THE CHILD?
No
MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.1A
No

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Chart 3.4.1 Continued

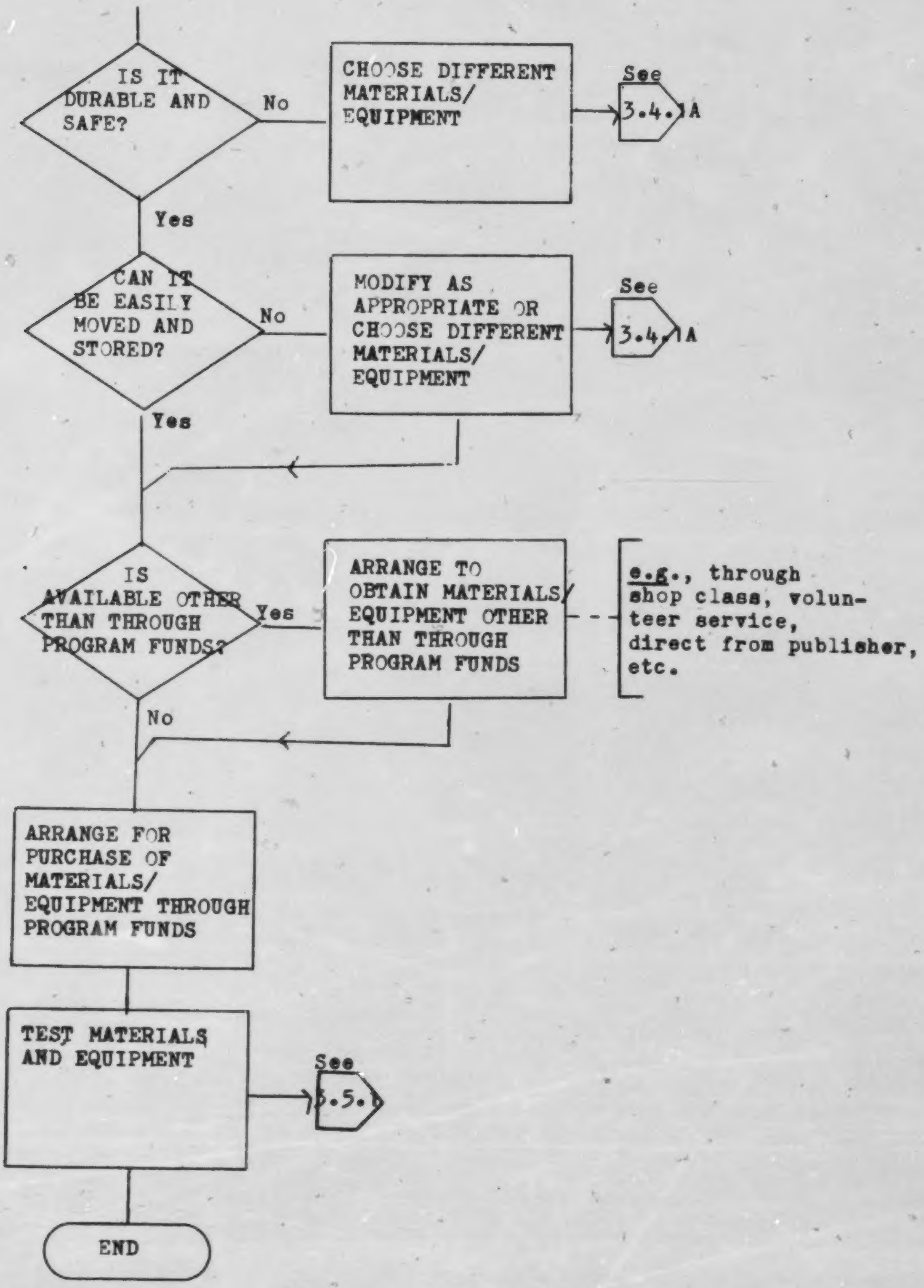
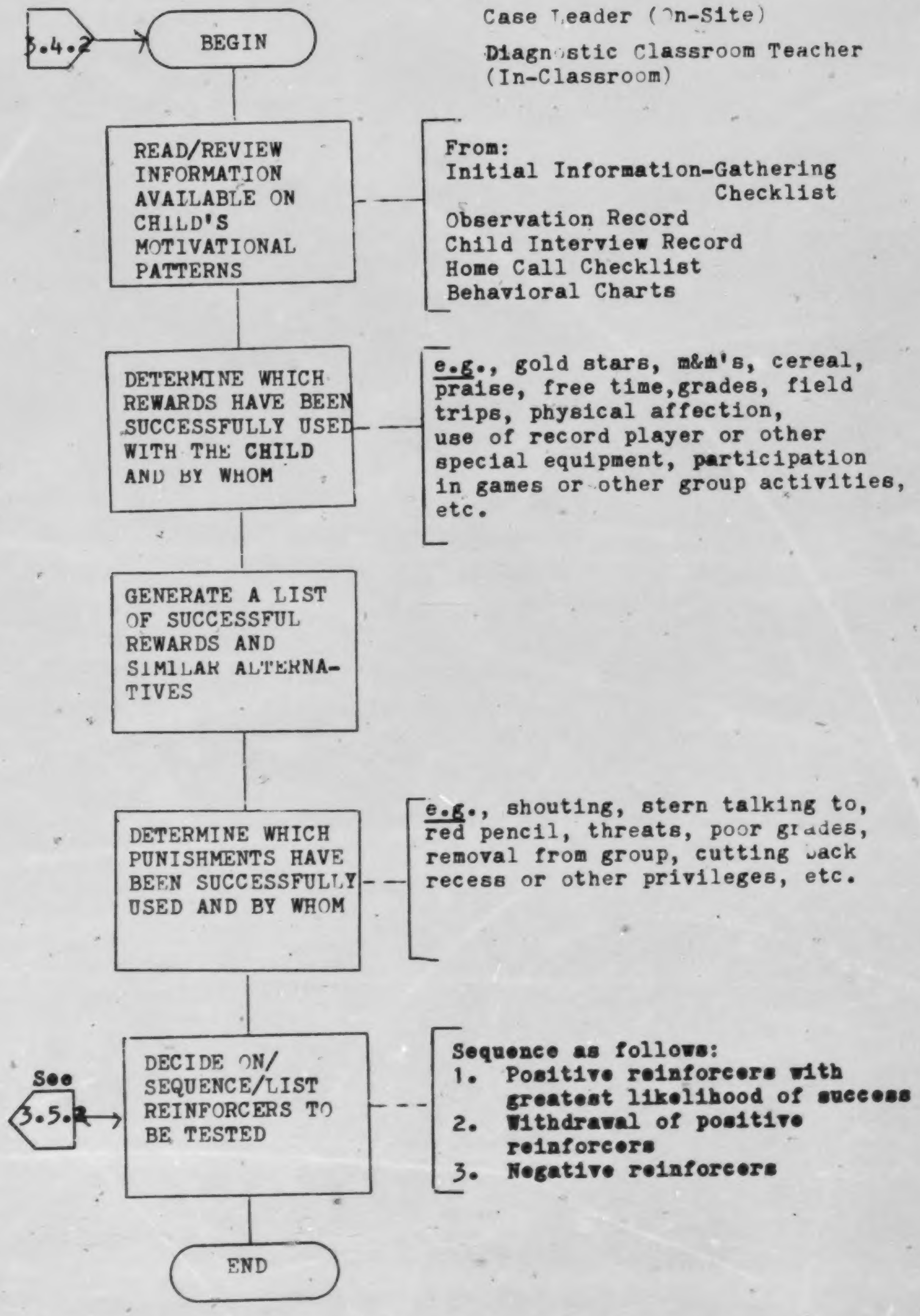

IS IT DURABLE AND SAFE?
No
CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See
3.4.1A
Yes
CAN IT BE EASILY MOVED AND STORED?
No
MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See
3.4.1A
Yes
IS AVAILABLE OTHER THAN THROUGH PROGRAM FUNDS?
Yes
ARRANGE TO OBTAIN MATERIALS/ EQUIPMENT OTHER THAN THROUGH PROGRAM FUNDS
e.g., through shop class, volunteer service, direct from publisher, etc.
No
ARRANGE FOR PURCHASE OF MATERIALS/ EQUIPMENT THROUGH PROGRAM FUNDS
TEST MATERIALS AND EQUIPMENT
See
3.5.1
END

Chart 3.4.2 SELECT/DEVISE REINFORCEMENT STRATEGIES

Case Leader (On-Site)

Diagnostic Classroom Teacher (In-Classroom)


3.4.2
BEGIN
READ/REVIEW INFORMATION AVAILABLE ON CHILD'S MOTIVATIONAL PATTERNS
DETERMINE WHICH REWARDS HAVE BEEN SUCCESSFULLY USED WITH THE CHILD AND BY WHOM
GENERATE A LIST OF SUCCESSFUL REWARDS AND SIMILAR ALTERNATIVES
DETERMINE WHICH PUNISHMENTS HAVE BEEN SUCCESSFULLY USED AND BY WHOM
DECIDE ON/SEQUENCE/LIST REINFORCERS TO BE TESTED
See 3.5.2
END

From:
Initial Information-Gathering Checklist
Observation Record
Child Interview Record
Home Call Checklist
Behavioral Charts

e.g., gold stars, m&m's, cereal, praise, free time, grades, field trips, physical affection, use of record player or other special equipment, participation in games or other group activities, etc.

e.g., shouting, stern talking to, red pencil, threats, poor grades, removal from group, cutting back recess or other privileges, etc.

Sequence as follows:
1. **Positive reinforcers with greatest likelihood of success**
2. **Withdrawal of positive reinforcers**
3. **Negative reinforcers**

Chart 3.5 TEST INITIAL PROGRAM PRESCRIPTIONS

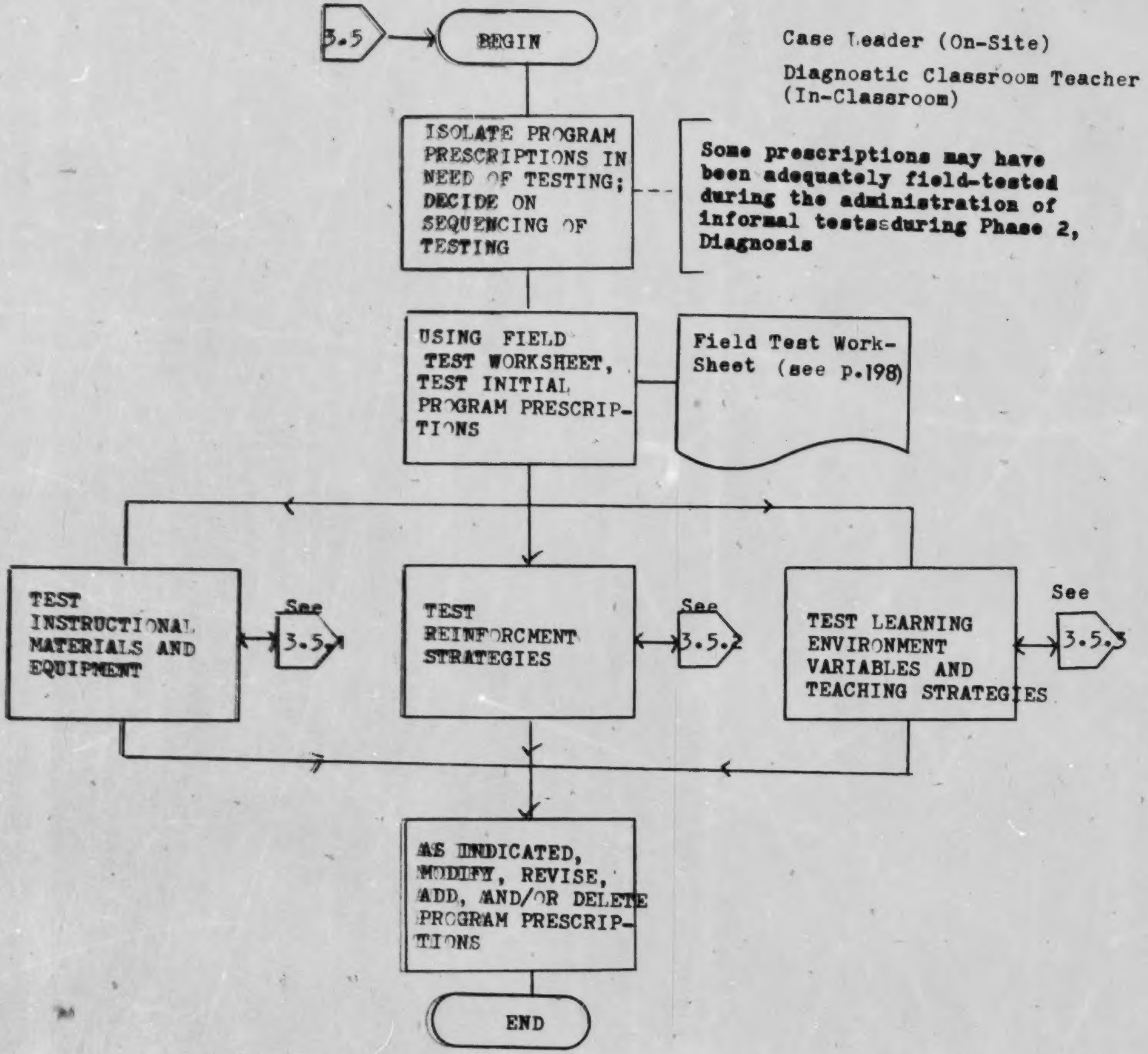
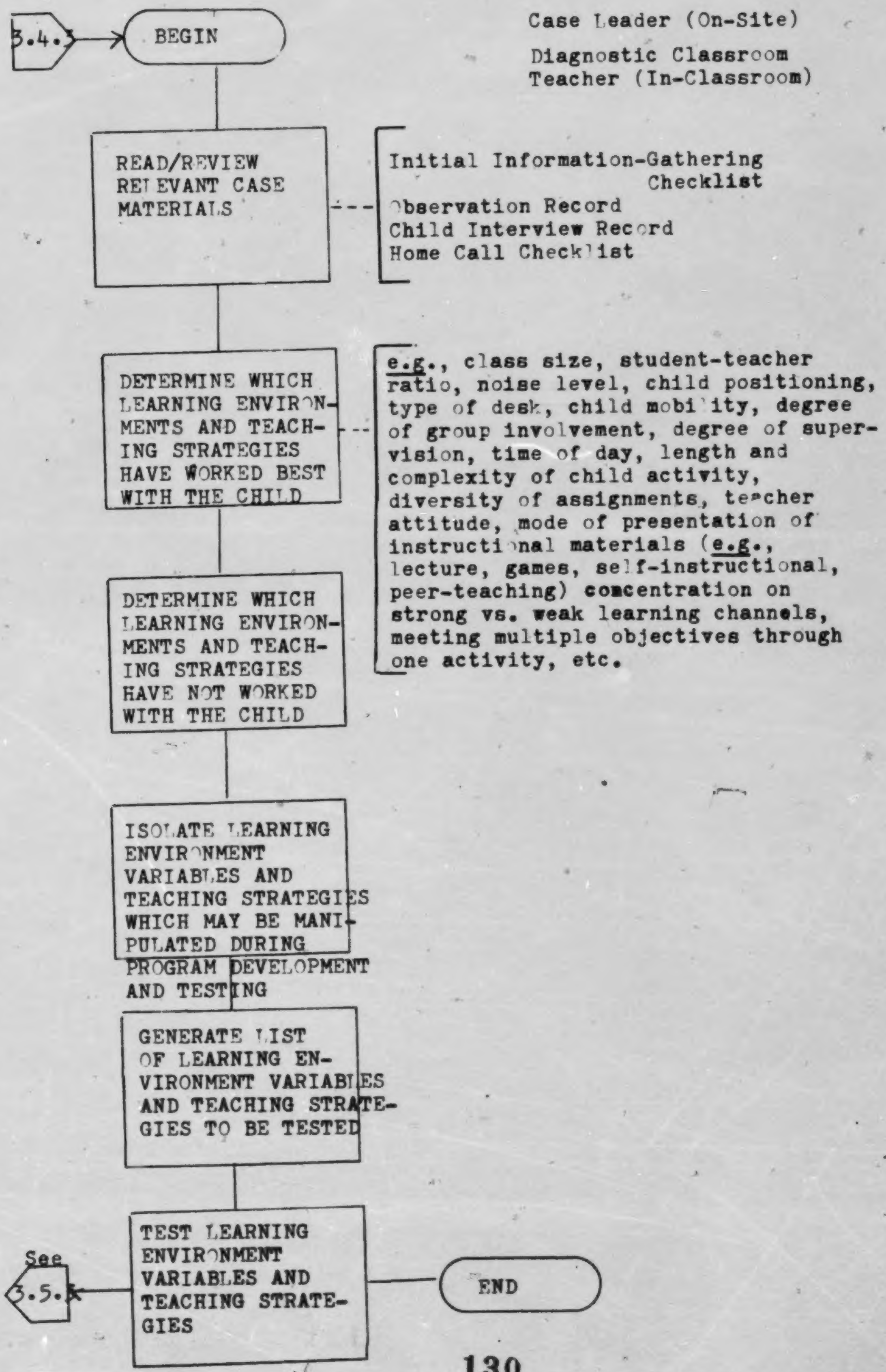

3.5
BEGIN
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
ISOLATE PROGRAM PRESCRIPTIONS IN NEED OF TESTING; DECIDE ON SEQUENCING OF TESTING
Some prescriptions may have been adequately field-tested during the administration of informal testsduring Phase 2, Diagnosis
USING FIELD TEST WORKSHEET, TEST INITIAL PROGRAM PRESCRIPTIONS
Field Test Work-Sheet (see p.198)
TEST INSTRUCTIONAL MATERIALS AND EQUIPMENT
See
3.5.1
TEST REINFORCMENT STRATEGIES
See
3.5.2
TEST LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES
See
3.5.3
AS INDICATED, MODIFY, REVISE, ADD, AND/OR DELETE PROGRAM PRESCRIPTIONS
END

Chart 3.4.3 **DETERMINE OPTIMAL LEARNING ENVIRONMENT AND TEACHING STRATEGIES**


3.4.3
BEGIN
READ/REVIEW RELEVANT CASE MATERIALS
DETERMINE WHICH LEARNING ENVIRONMENTS AND TEACHING STRATEGIES HAVE WORKED BEST WITH THE CHILD
DETERMINE WHICH LEARNING ENVIRONMENTS AND TEACHING STRATEGIES HAVE NOT WORKED WITH THE CHILD
ISOLATE LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES WHICH MAY BE MANIPULATED DURING PROGRAM DEVELOPMENT AND TESTING
GENERATE LIST OF LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES TO BE TESTED
TEST LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES
See
3.5.1
END

Case Leader (On-Site)

Diagnostic Classroom
Teacher (In-Classroom)

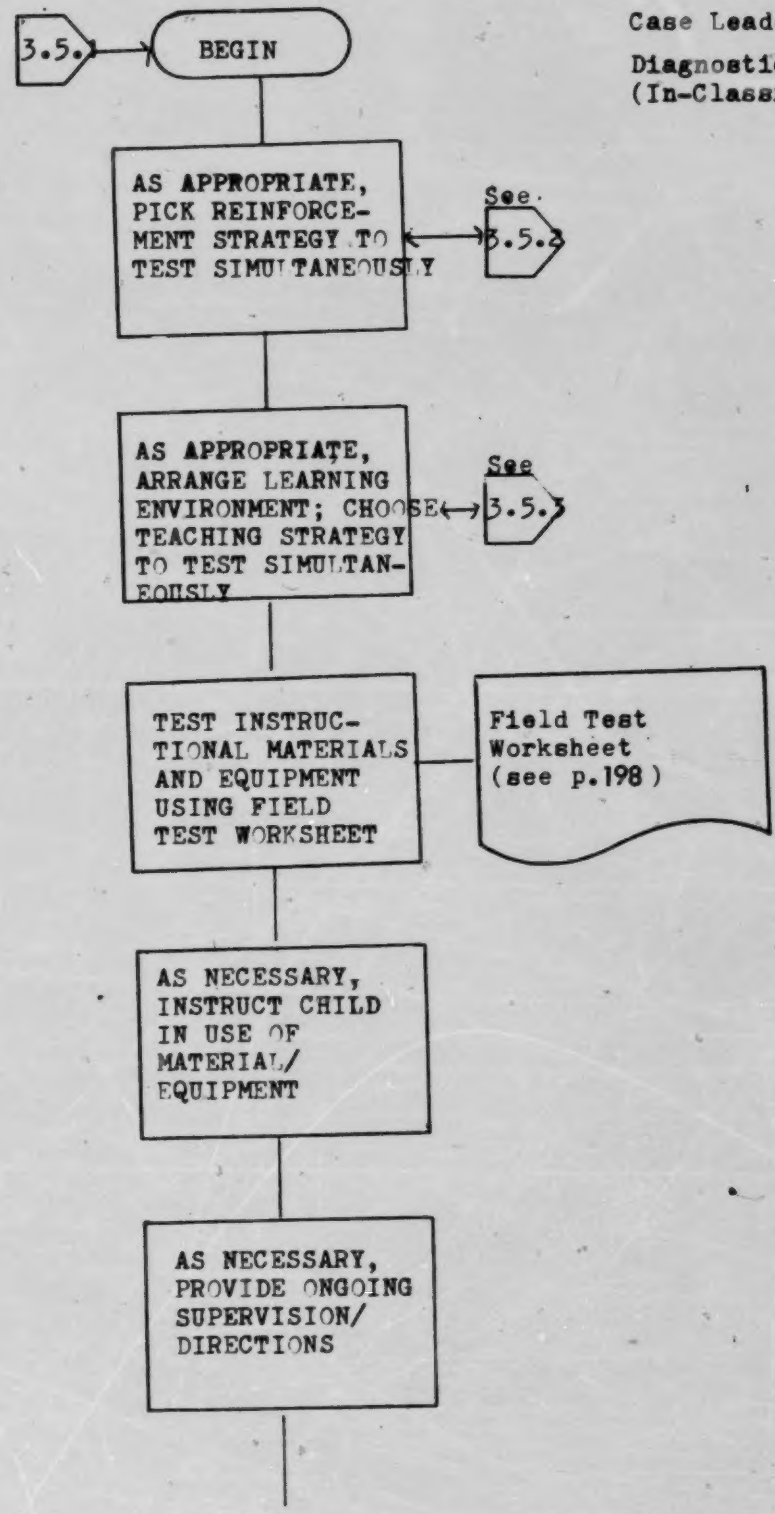
Initial Information-Gathering Checklist
Observation Record
Child Interview Record
Home Call Checklist

e.g., class size, student-teacher ratio, noise level, child positioning, type of desk, child mobility, degree of group involvement, degree of supervision, time of day, length and complexity of child activity, diversity of assignments, teacher attitude, mode of presentation of instructional materials (e.g., lecture, games, self-instructional, peer-teaching) concentration on strong vs. weak learning channels, meeting multiple objectives through one activity, etc.

Chart 3.5.1 TEST INSTRUCTIONAL MATERIALS AND EQUIPMENT

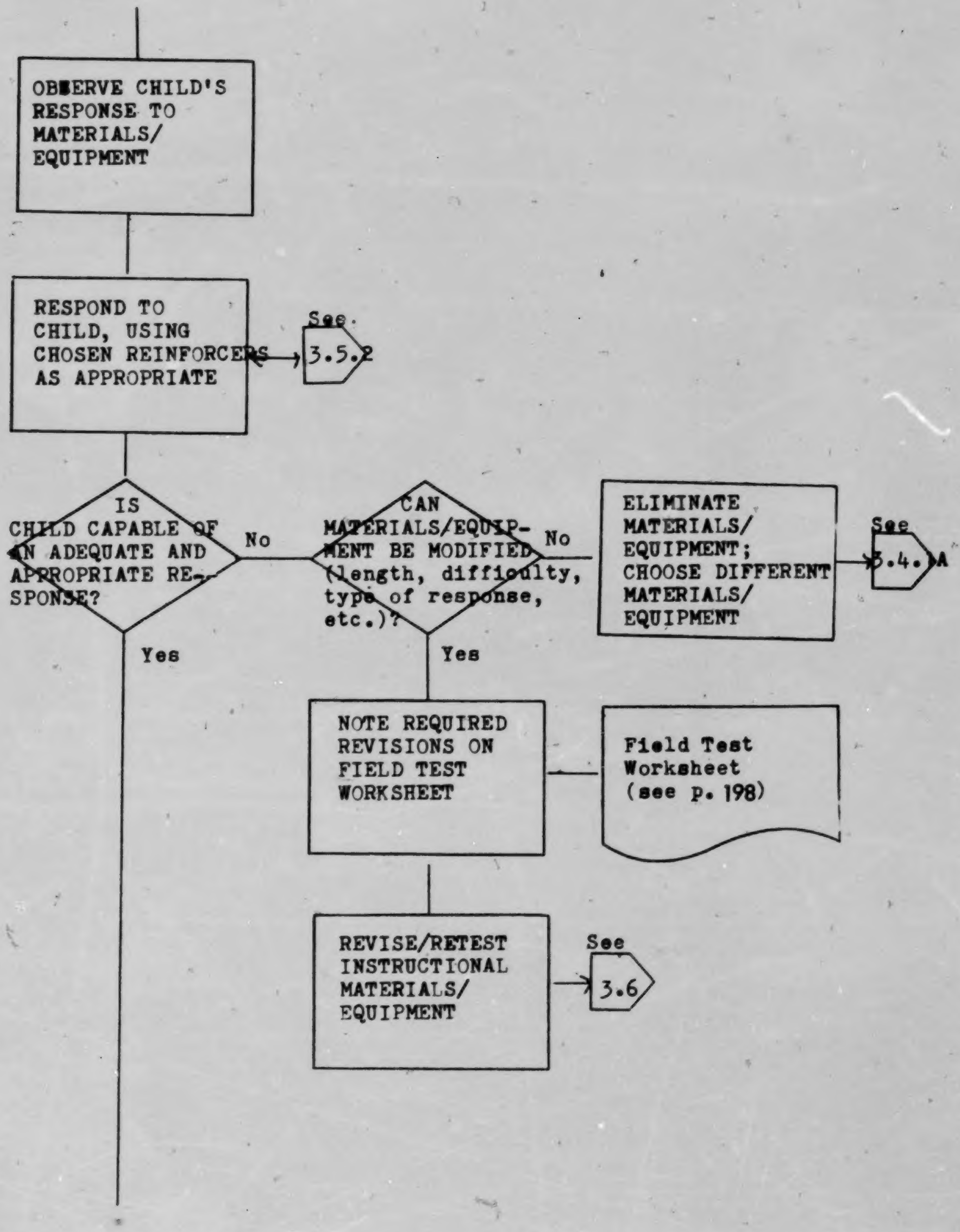
Case Leader (On-Site)

Diagnostic Classroom Teacher
(In-Classroom


3.5.
BEGIN
AS APPROPRIATE, PICK REINFORCEMENT STRATEGY TO TEST SIMULTANEOUSLY
See
3.5.2
AS APPROPRIATE, ARRANGE LEARNING ENVIRONMENT; CHOOSE TEACHING STRATEGY TO TEST SIMULTANEOUSLY
See
3.5.3
TEST INSTRUCTIONAL MATERIALS AND EQUIPMENT USING FIELD TEST WORKSHEET
Field Test Worksheet (see p.198)
AS NECESSARY, INSTRUCT CHILD IN USE OF MATERIAL/EQUIPMENT
AS NECESSARY, PROVIDE ONGOING SUPERVISION/DIRECTIONS

Continued on next page

Chart 3.5.1 Continued


OBSERVE CHILD'S RESPONSE TO MATERIALS/ EQUIPMENT
RESPOND TO CHILD, USING CHOSEN REINFORCERS AS APPROPRIATE
See 3.5.2
IS CHILD CAPABLE OF AN ADEQUATE AND APPROPRIATE RESPONSE?
No
Yes
CAN MATERIALS/EQUIPMENT BE MODIFIED (length, difficulty, type of response, etc.)?
No
Yes
ELIMINATE MATERIALS/ EQUIPMENT; CHOOSE DIFFERENT MATERIALS/ EQUIPMENT
See 3.4.A
NOTE REQUIRED REVISIONS ON FIELD TEST WORKSHEET
Field Test Worksheet (see p. 198)
REVISE/RETEST INSTRUCTIONAL MATERIALS/ EQUIPMENT
See 3.6

Continued on next page

Page two of three

Chart 3.5.1 Continued

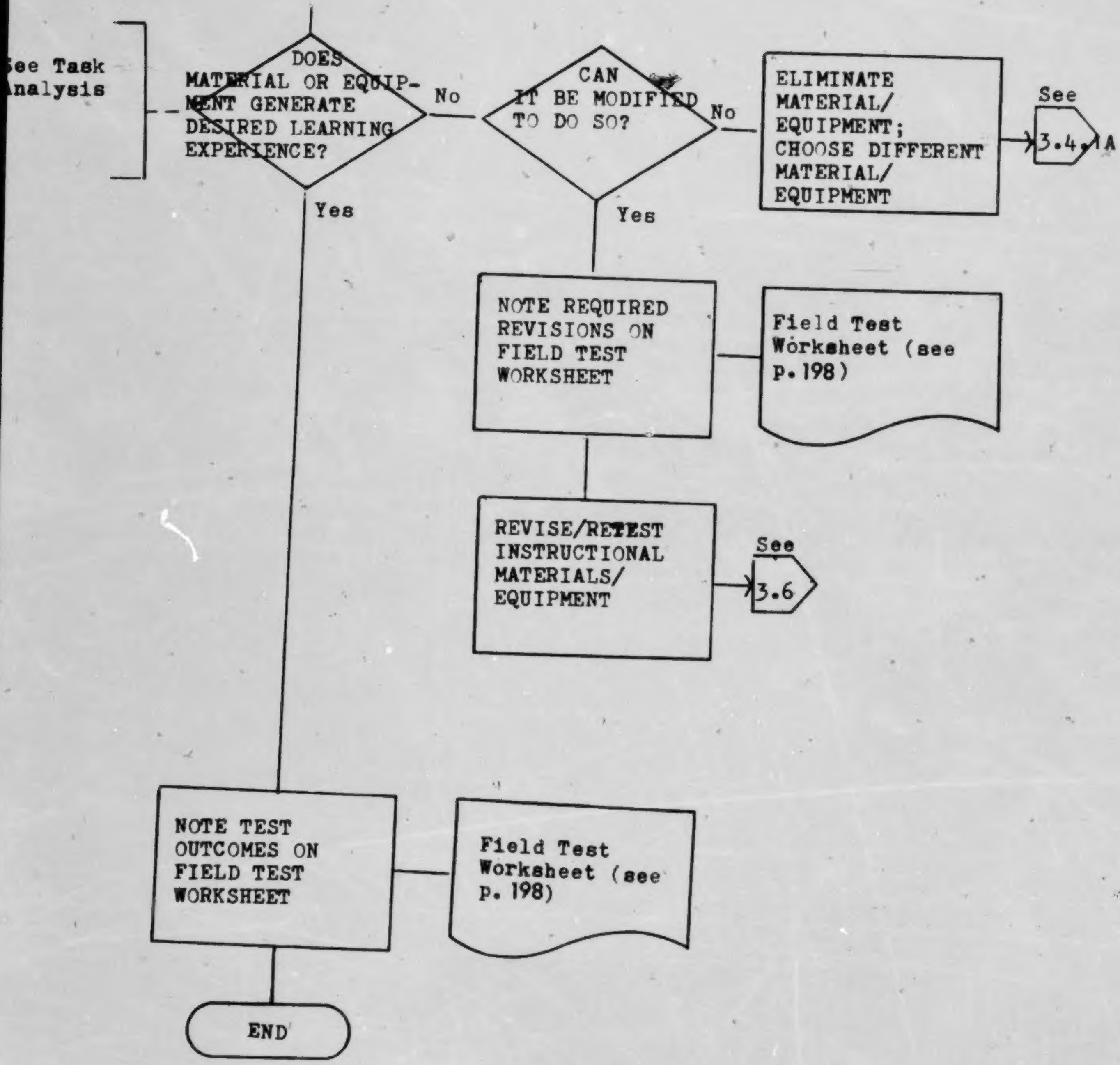
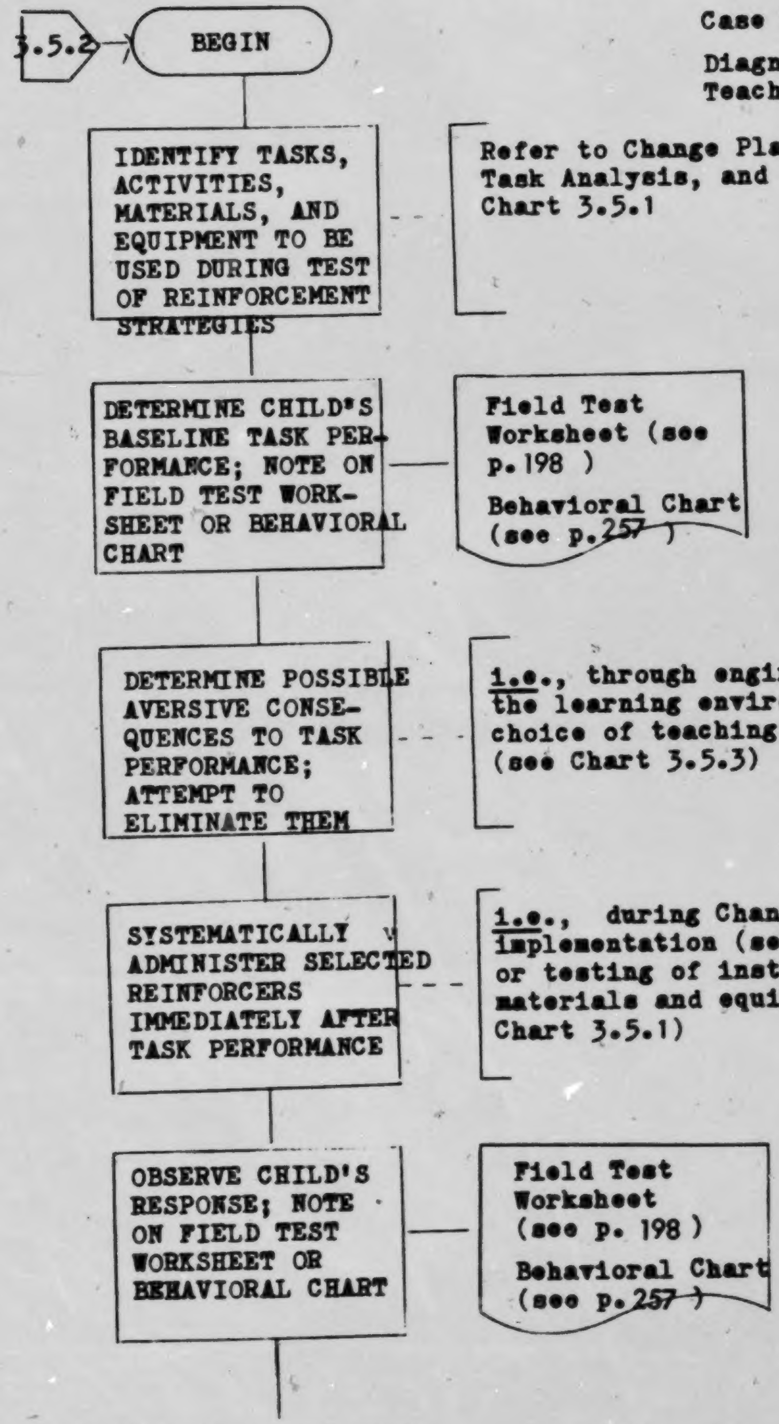

See Task Analysis
DOES MATERIAL OR EQUIPMENT GENERATE DESIRED LEARNING EXPERIENCE?
No
CAN IT BE MODIFIED TO DO SO?
No
ELIMINATE MATERIAL/ EQUIPMENT; CHOOSE DIFFERENT MATERIAL/ EQUIPMENT
See
3.4.1A
Yes
Yes
NOTE REQUIRED REVISIONS ON FIELD TEST WORKSHEET
Field Test Worksheet (see p. 198)
REVISE/RETEST INSTRUCTIONAL MATERIALS/ EQUIPMENT
See
3.6
NOTE TEST OUTCOMES ON FIELD TEST WORKSHEET
Field Test Worksheet (see p. 198)
END

Chart 3.5.2 TEST REINFORCEMENT STRATEGIES

Case Leader (On-Site)

Diagnostic Classroom Teacher (In-Classroom)


3.5.2
BEGIN
IDENTIFY TASKS, ACTIVITIES, MATERIALS, AND EQUIPMENT TO BE USED DURING TEST OF REINFORCEMENT STRATEGIES
DETERMINE CHILD'S BASELINE TASK PERFORMANCE; NOTE ON FIELD TEST WORKSHEET OR BEHAVIORAL CHART
DETERMINE POSSIBLE AVERSIVE CONSEQUENCES TO TASK PERFORMANCE; ATTEMPT TO ELIMINATE THEM
SYSTEMATICALLY ADMINISTER SELECTED REINFORCERS IMMEDIATELY AFTER TASK PERFORMANCE
OBSERVE CHILD'S RESPONSE; NOTE ON FIELD TEST WORKSHEET OR BEHAVIORAL CHART

Refer to Change Plan, Task Analysis, and Chart 3.5.1

Field Test Worksheet (see p. 198)

Behavioral Chart (see p. 257)

i.e., through engineering of the learning environment and/or choice of teaching strategies (see Chart 3.5.3)

i.e., during Change Plan implementation (see Chart 2.2) or testing of instructional materials and equipment (see Chart 3.5.1)

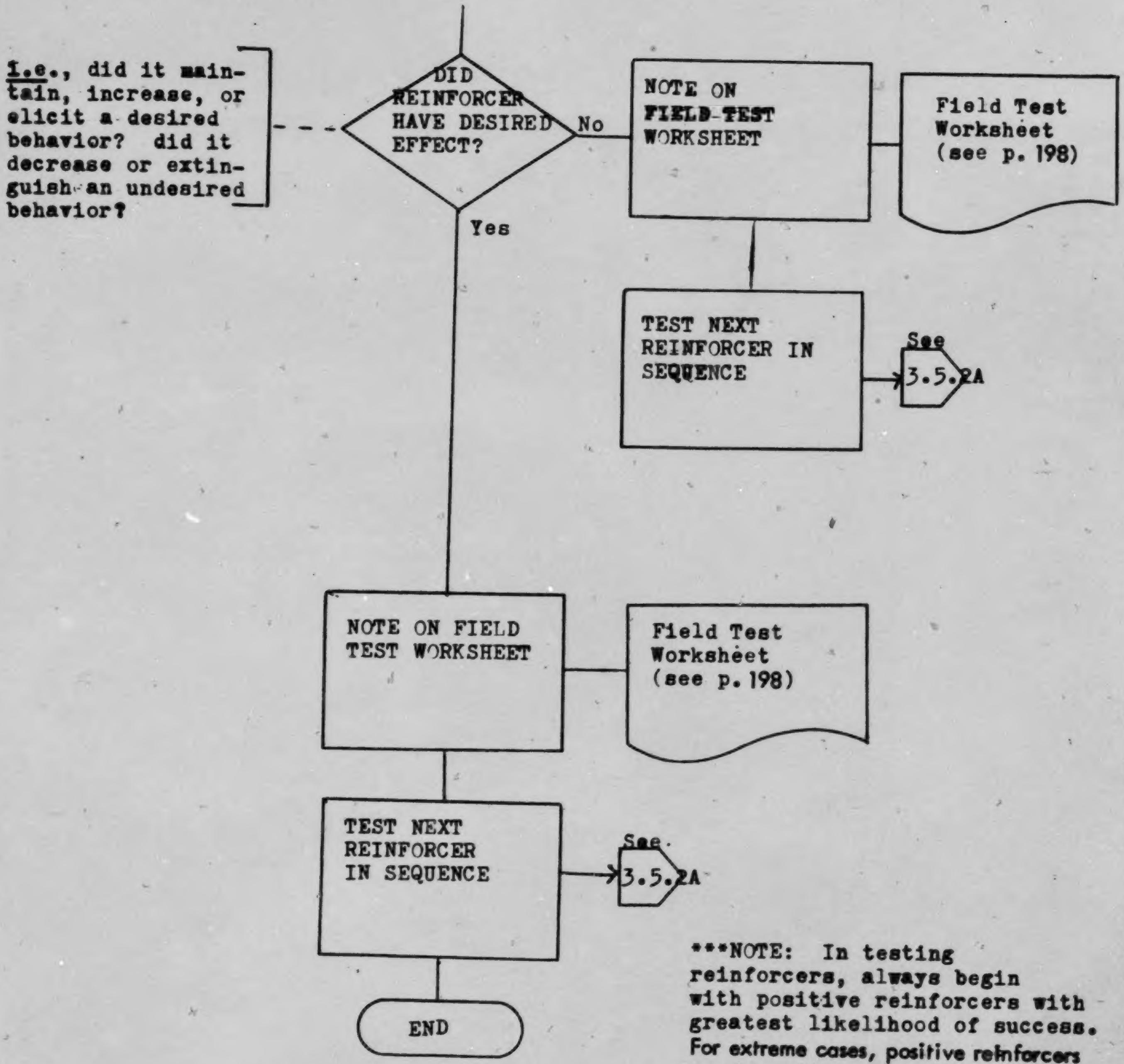
Field Test Worksheet (see p. 198)

Behavioral Chart (see p. 257)

Continued on next page

Page one of two

Chart 3.5.2 Continued

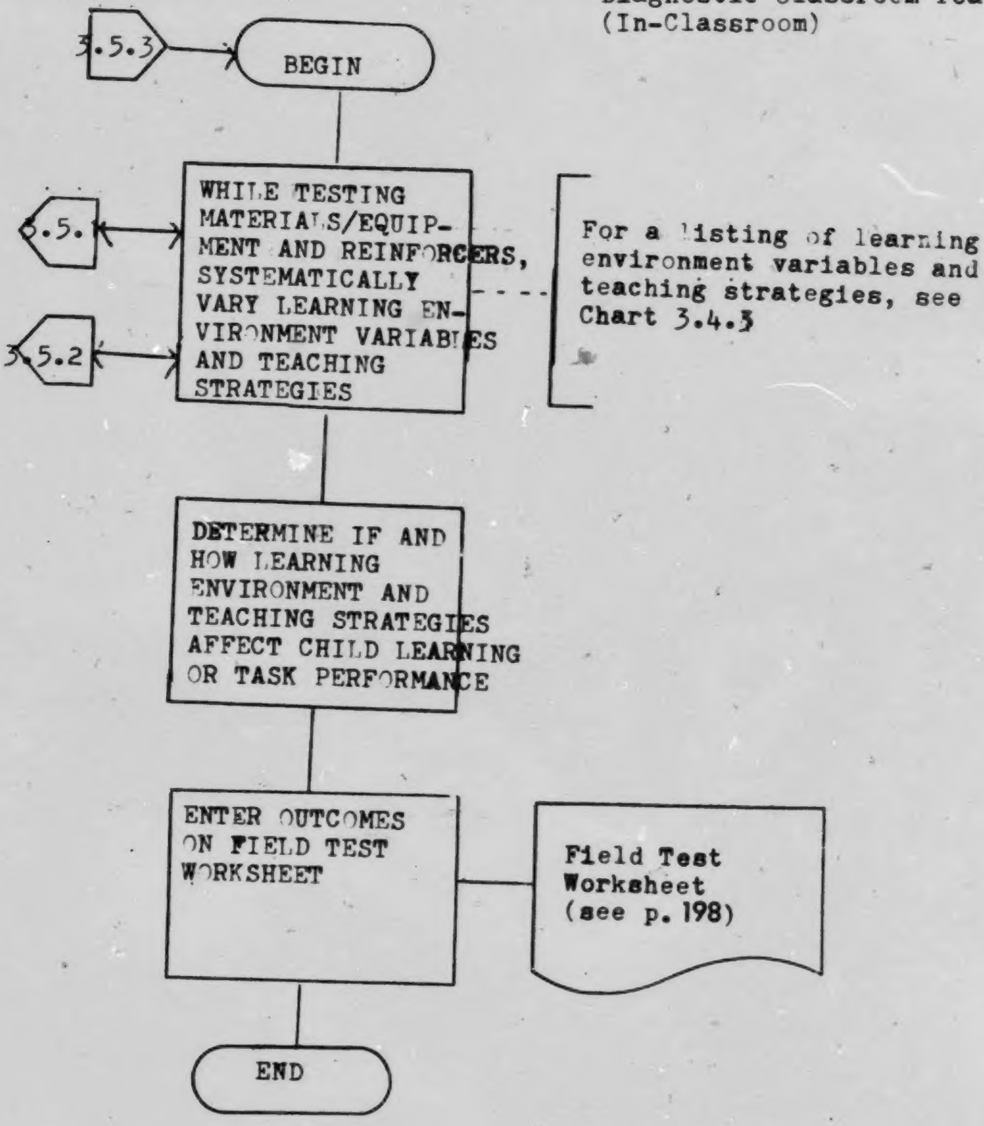

i.e., did it maintain, increase, or elicit a desired behavior? did it decrease or extinguish an undesired behavior?
DID REINFORCER HAVE DESIRED EFFECT?
No
NOTE ON ~~FIELD TEST~~ WORKSHEET
Field Test Worksheet (see p. 198)
TEST NEXT REINFORCER IN SEQUENCE
See 3.5.2A
Yes
NOTE ON FIELD TEST WORKSHEET
Field Test Worksheet (see p. 198)
TEST NEXT REINFORCER IN SEQUENCE
See 3.5.2A
END

***NOTE: In testing reinforcers, always begin with positive reinforcers with greatest likelihood of success. For extreme cases, positive reinforcers may be withheld, however, if a reinforcer is truly positive in the first place, negative ones should not be necessary.

Chart 3.5.3 TEST LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES

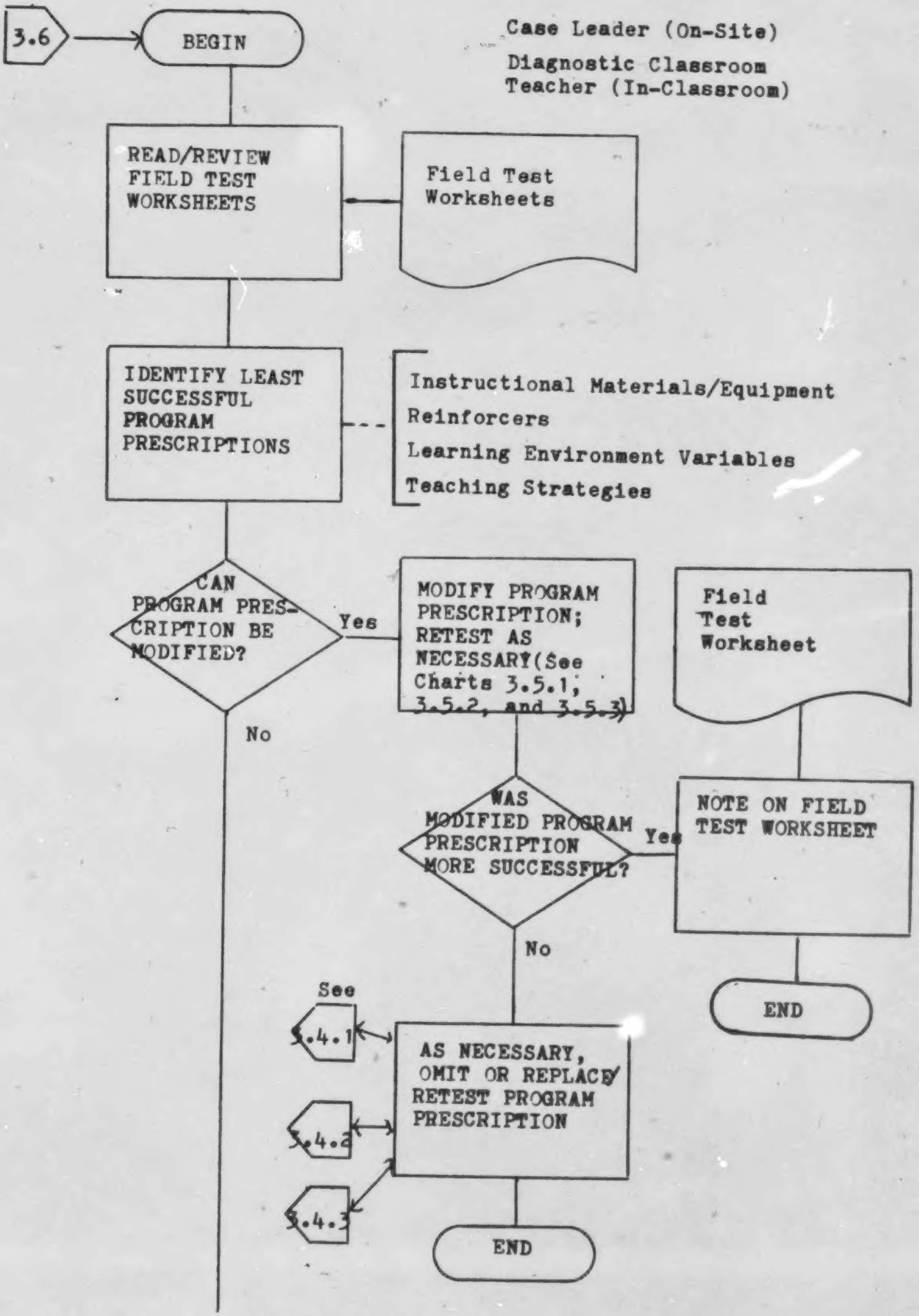
Case Leader (On-Site)

Diagnostic Classroom Teacher (In-Classroom)


3.5.3
BEGIN
3.5.
3.5.2
WHILE TESTING MATERIALS/EQUIPMENT AND REINFORCERS, SYSTEMATICALLY VARY LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES
DETERMINE IF AND HOW LEARNING ENVIRONMENT AND TEACHING STRATEGIES AFFECT CHILD LEARNING OR TASK PERFORMANCE
ENTER OUTCOMES ON FIELD TEST WORKSHEET
Field Test Worksheet (see p. 198)
END

For a listing of learning environment variables and teaching strategies, see Chart 3.4.3

Chart 3.6 REVISE/RETEST PROGRAM PRESCRIPTIONS


3.6
BEGIN
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
READ/REVIEW FIELD TEST WORKSHEETS
Field Test Worksheets
IDENTIFY LEAST SUCCESSFUL PROGRAM PRESCRIPTIONS
Instructional Materials/Equipment
Reinforcers
Learning Environment Variables
Teaching Strategies
CAN PROGRAM PRESCRIPTION BE MODIFIED?
Yes
No
MODIFY PROGRAM PRESCRIPTION; RETEST AS NECESSARY (See Charts 3.5.1, 3.5.2, and 3.5.3)
Field Test Worksheet
WAS MODIFIED PROGRAM PRESCRIPTION MORE SUCCESSFUL?
Yes
No
NOTE ON FIELD TEST WORKSHEET
END
See
3.4.1
3.4.2
3.4.3
AS NECESSARY, OMIT OR REPLACE/RETEST PROGRAM PRESCRIPTION
END

Continued on next page

Page one of two

Chart 3.6 Continued

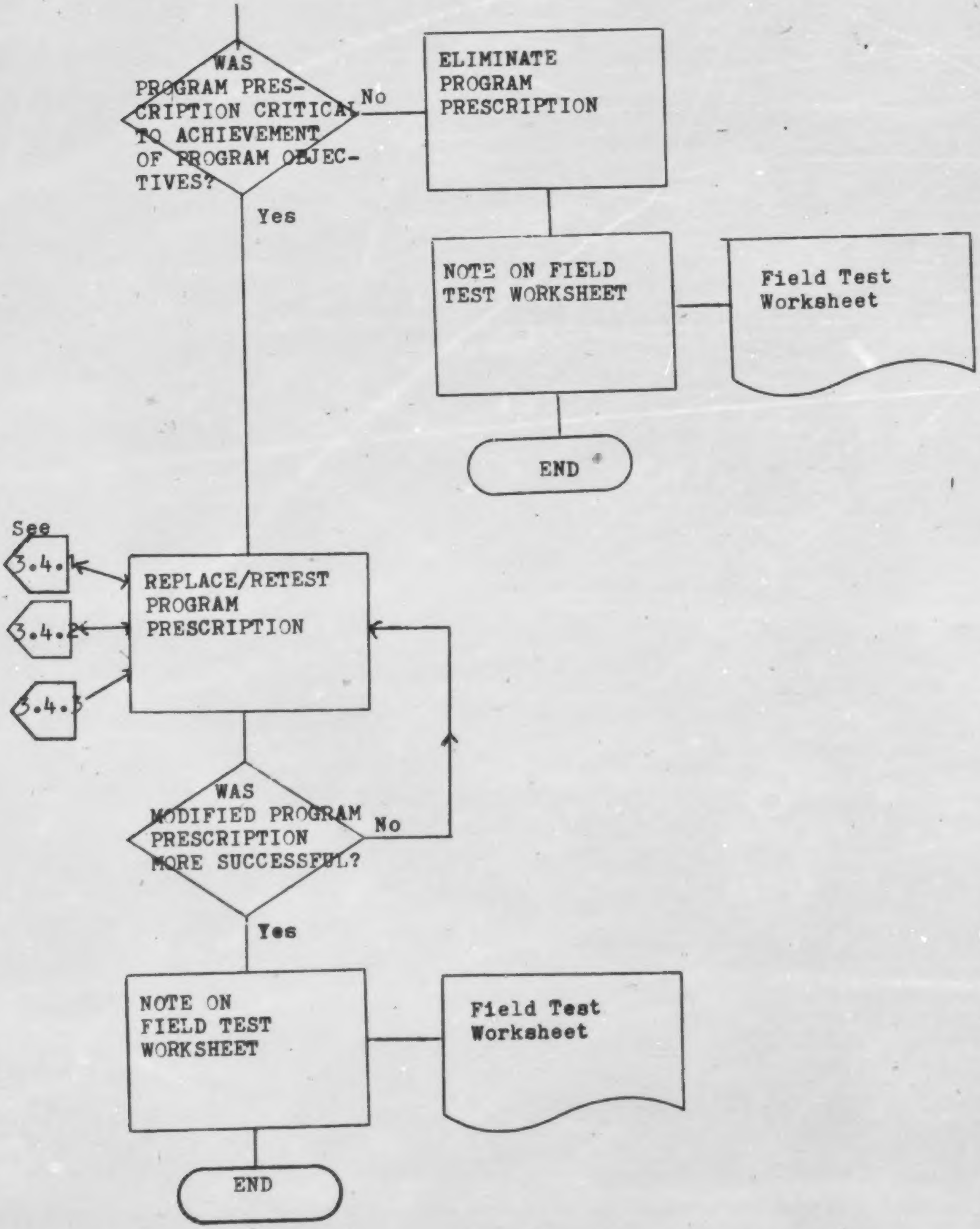
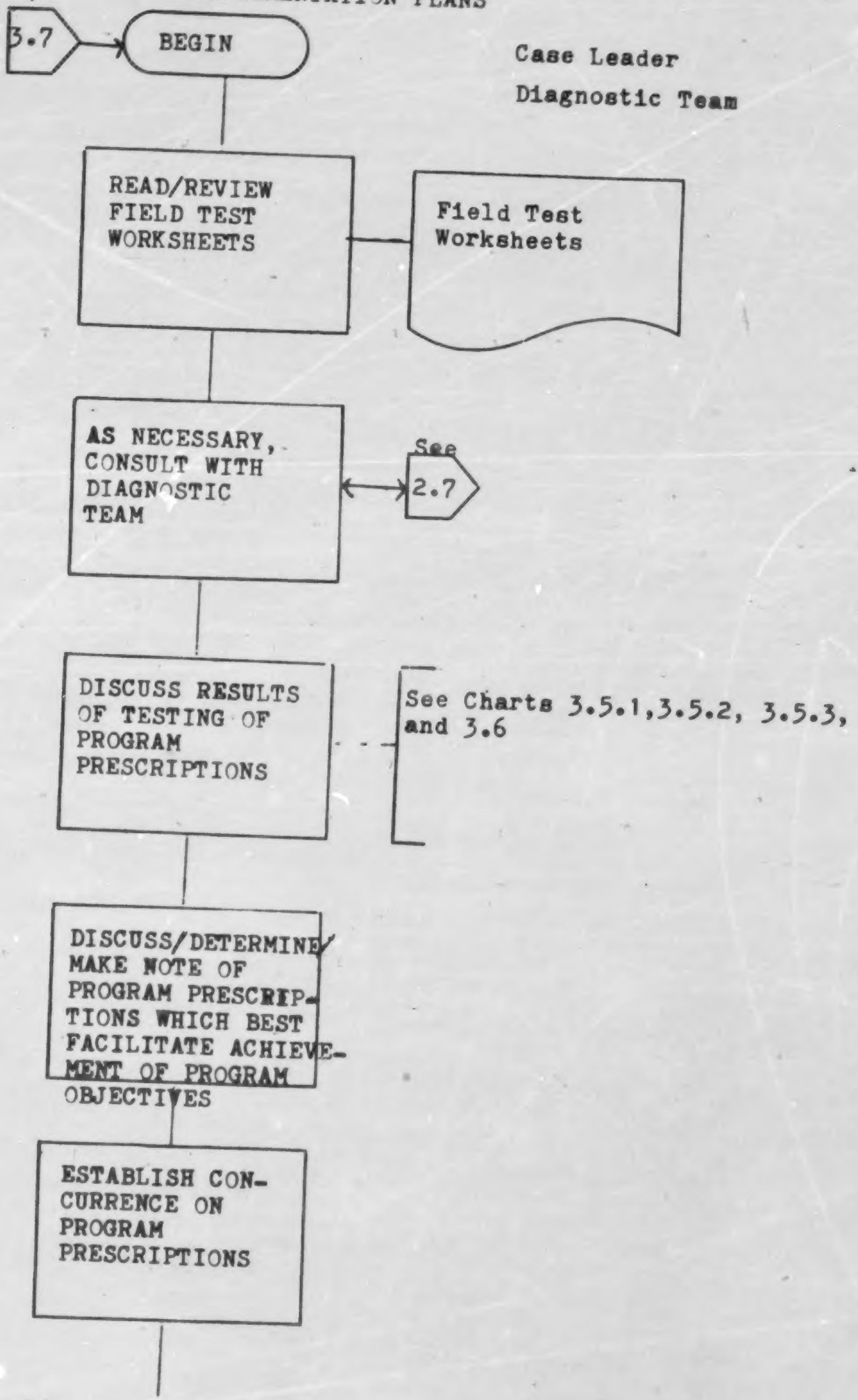
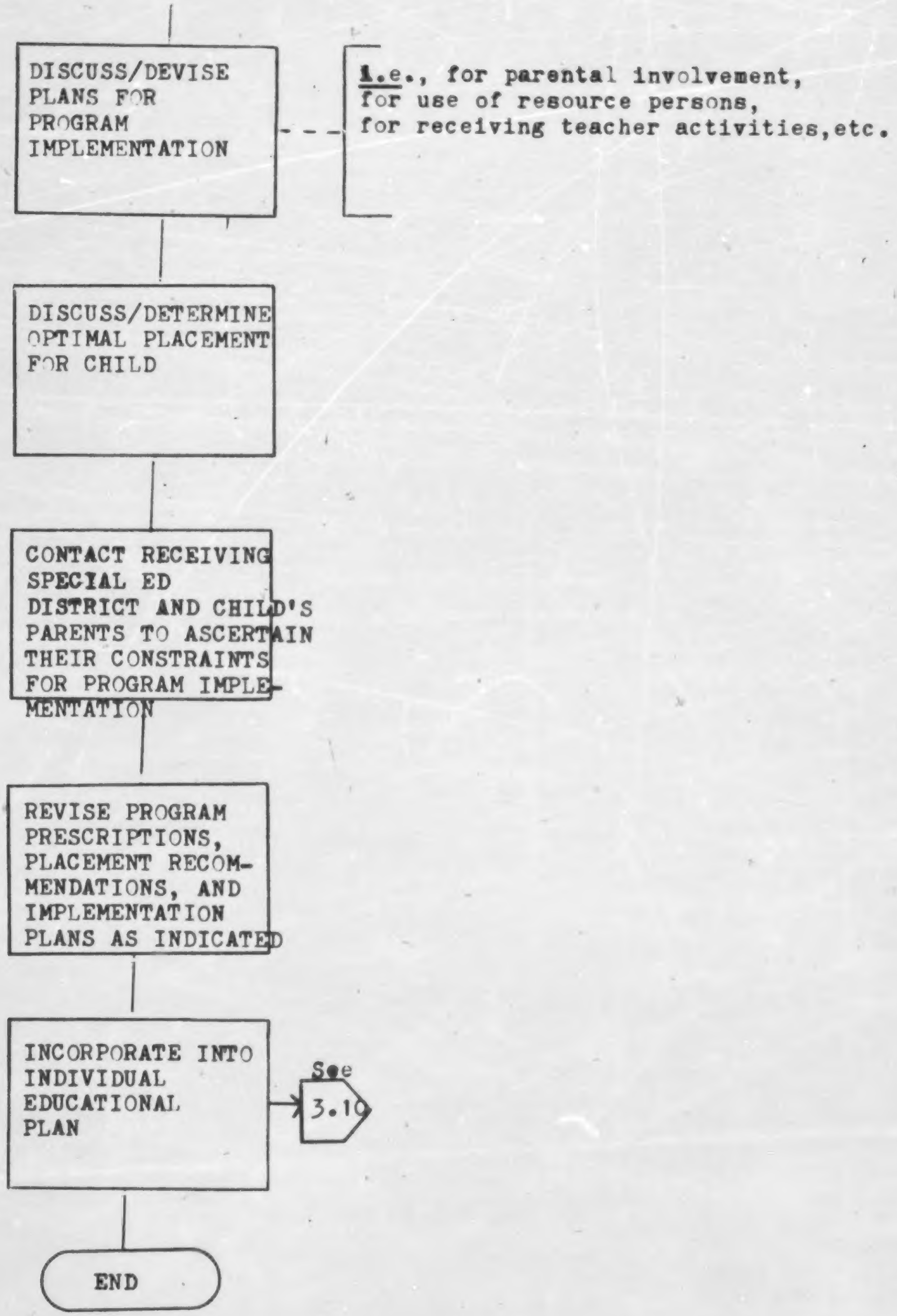

WAS PROGRAM PRESCRIPTION CRITICAL TO ACHIEVEMENT OF PROGRAM OBJECTIVES?
No
ELIMINATE PROGRAM PRESCRIPTION
NOTE ON FIELD TEST WORKSHEET
Field Test Worksheet
END
Yes
See
3.4.1
3.4.2
3.4.3
REPLACE/RETEST PROGRAM PRESCRIPTION
WAS MODIFIED PROGRAM PRESCRIPTION MORE SUCCESSFUL?
No
Yes
NOTE ON FIELD TEST WORKSHEET
Field Test Worksheet
END

Chart 3.7 FINALIZE PROGRAM PRESCRIPTIONS, PLACEMENT RECOMMENDATIONS, AND IMPLEMENTATION PLANS


3.7
BEGIN
Case Leader
Diagnostic Team
READ/REVIEW FIELD TEST WORKSHEETS
Field Test Worksheets
AS NECESSARY, CONSULT WITH DIAGNOSTIC TEAM
See 2.7
DISCUSS RESULTS OF TESTING OF PROGRAM PRESCRIPTIONS
See Charts 3.5.1, 3.5.2, 3.5.3, and 3.6
DISCUSS/DETERMINE/ MAKE NOTE OF PROGRAM PRESCRIPTIONS WHICH BEST FACILITATE ACHIEVEMENT OF PROGRAM OBJECTIVES
ESTABLISH CONCURRENCE ON PROGRAM PRESCRIPTIONS

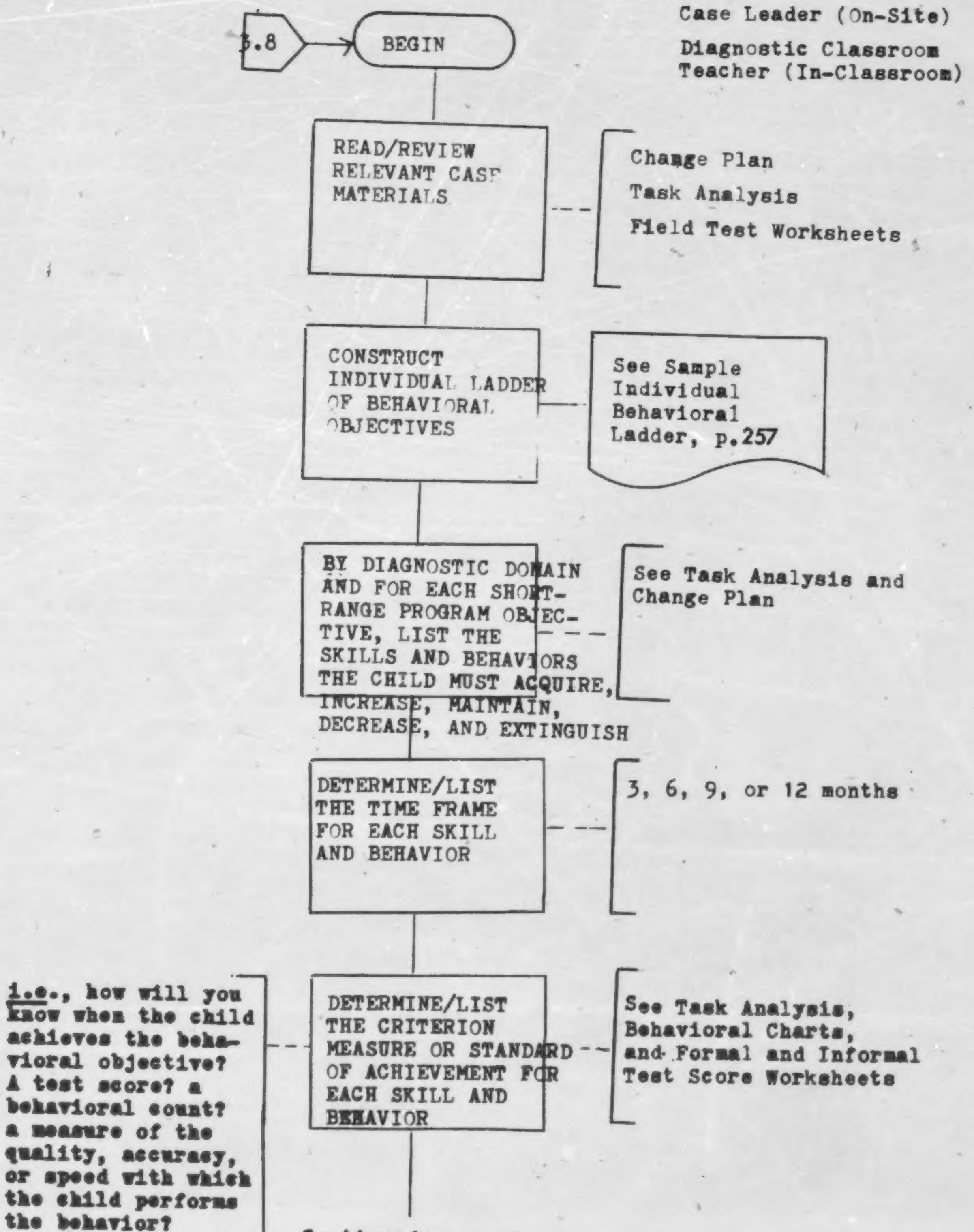
Continued on next page

Chart 3.7 Continued


DISCUSS/DEVISE PLANS FOR PROGRAM IMPLEMENTATION
i.e., for parental involvement, for use of resource persons, for receiving teacher activities, etc.
DISCUSS/DETERMINE OPTIMAL PLACEMENT FOR CHILD
CONTACT RECEIVING SPECIAL ED DISTRICT AND CHILD'S PARENTS TO ASCERTAIN THEIR CONSTRAINTS FOR PROGRAM IMPLEMENTATION
REVISE PROGRAM PRESCRIPTIONS, PLACEMENT RECOMMENDATIONS, AND IMPLEMENTATION PLANS AS INDICATED
INCORPORATE INTO INDIVIDUAL EDUCATIONAL PLAN
See
3.10
END

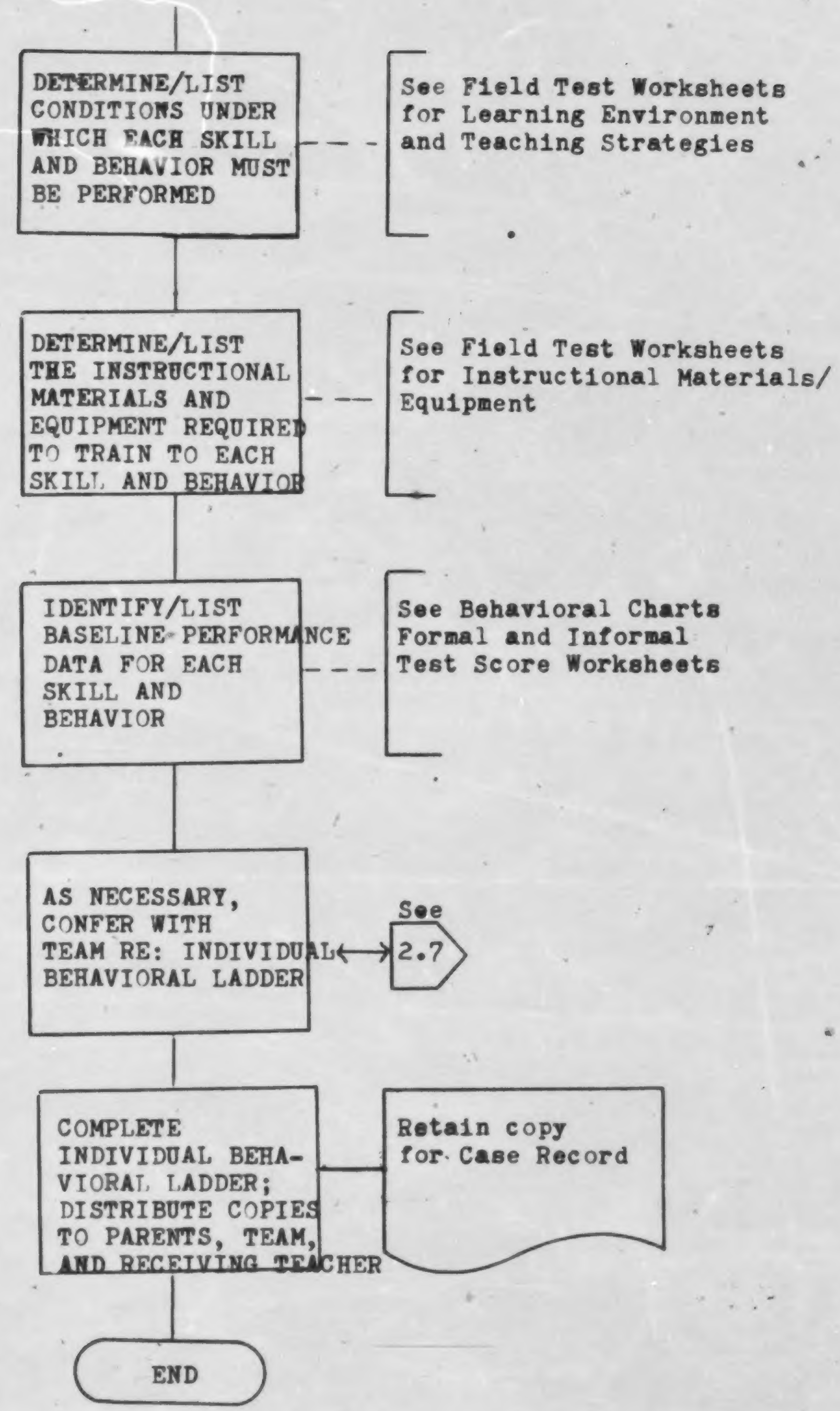
Page two of two

Chart 3.8 CONSTRUCT INDIVIDUAL BEHAVIORAL LADDER


3.8
BEGIN
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
READ/REVIEW RELEVANT CASE MATERIALS
Change Plan
Task Analysis
Field Test Worksheets
CONSTRUCT INDIVIDUAL LADDER OF BEHAVIORAL OBJECTIVES
See Sample Individual Behavioral Ladder, p.257
BY DIAGNOSTIC DOMAIN AND FOR EACH SHORT-RANGE PROGRAM OBJECTIVE, LIST THE SKILLS AND BEHAVIORS THE CHILD MUST ACQUIRE, INCREASE, MAINTAIN, DECREASE, AND EXTINGUISH
See Task Analysis and Change Plan
DETERMINE/LIST THE TIME FRAME FOR EACH SKILL AND BEHAVIOR
3, 6, 9, or 12 months
i.e., how will you know when the child achieves the behavioral objective? A test score? a behavioral count? a measure of the quality, accuracy, or speed with which the child performs the behavior?
DETERMINE/LIST THE CRITERION MEASURE OR STANDARD OF ACHIEVEMENT FOR EACH SKILL AND BEHAVIOR
See Task Analysis, Behavioral Charts, and Formal and Informal Test Score Worksheets

Continued on next page.

Chart 3.8 Continued


DETERMINE/LIST CONDITIONS UNDER WHICH EACH SKILL AND BEHAVIOR MUST BE PERFORMED
See Field Test Worksheets for Learning Environment and Teaching Strategies
DETERMINE/LIST THE INSTRUCTIONAL MATERIALS AND EQUIPMENT REQUIRED TO TRAIN TO EACH SKILL AND BEHAVIOR
See Field Test Worksheets for Instructional Materials/ Equipment
IDENTIFY/LIST BASELINE PERFORMANCE DATA FOR EACH SKILL AND BEHAVIOR
See Behavioral Charts Formal and Informal Test Score Worksheets
AS NECESSARY, CONFER WITH TEAM RE: INDIVIDUAL BEHAVIORAL LADDER
See
2.7
COMPLETE INDIVIDUAL BEHAVIORAL LADDER; DISTRIBUTE COPIES TO PARENTS, TEAM, AND RECEIVING TEACHER
Retain copy for Case Record
END

Page two of two

Chart 3.9 DEVISE PLANS FOR FOLLOW-UP SERVICES AND DATA COLLECTION

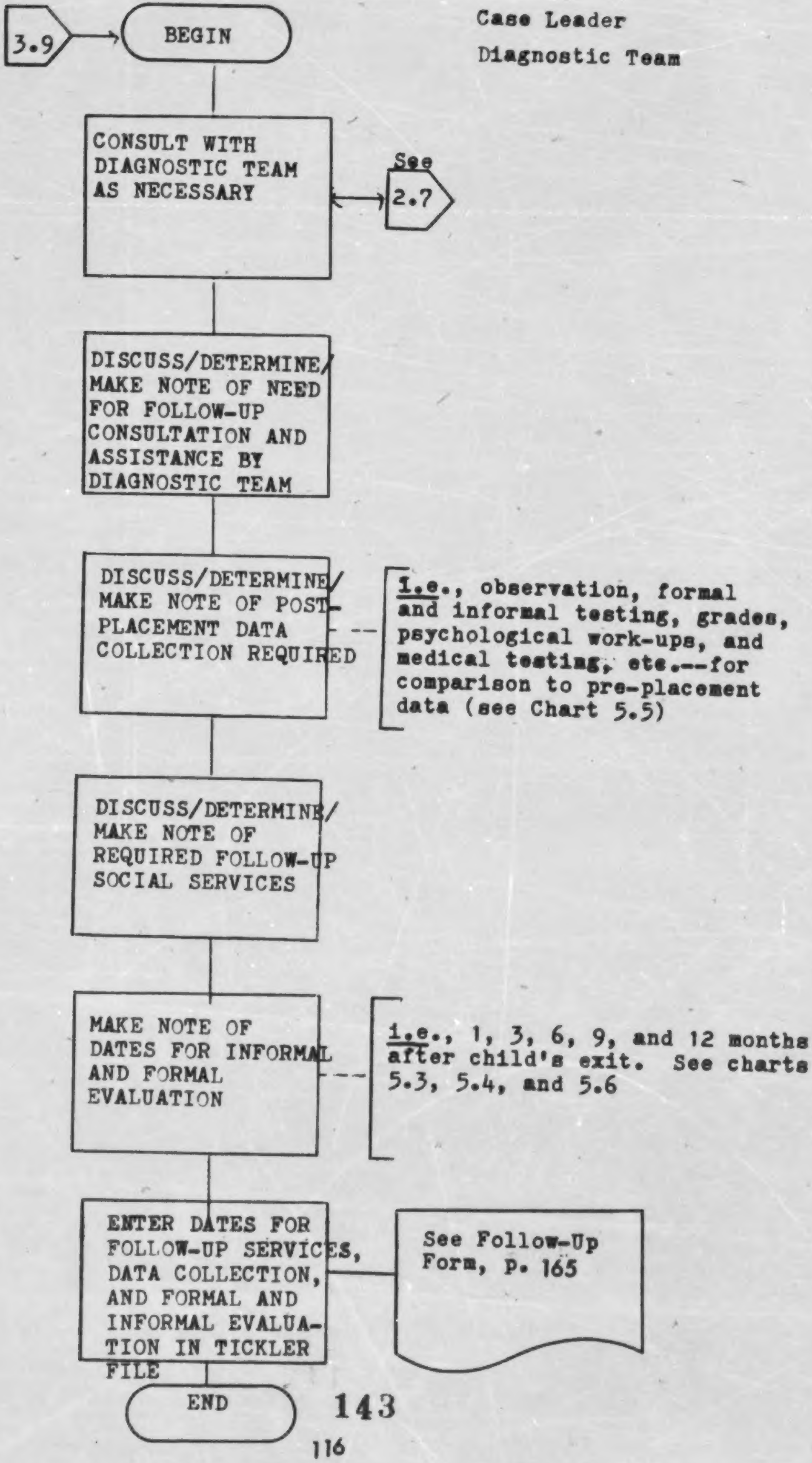
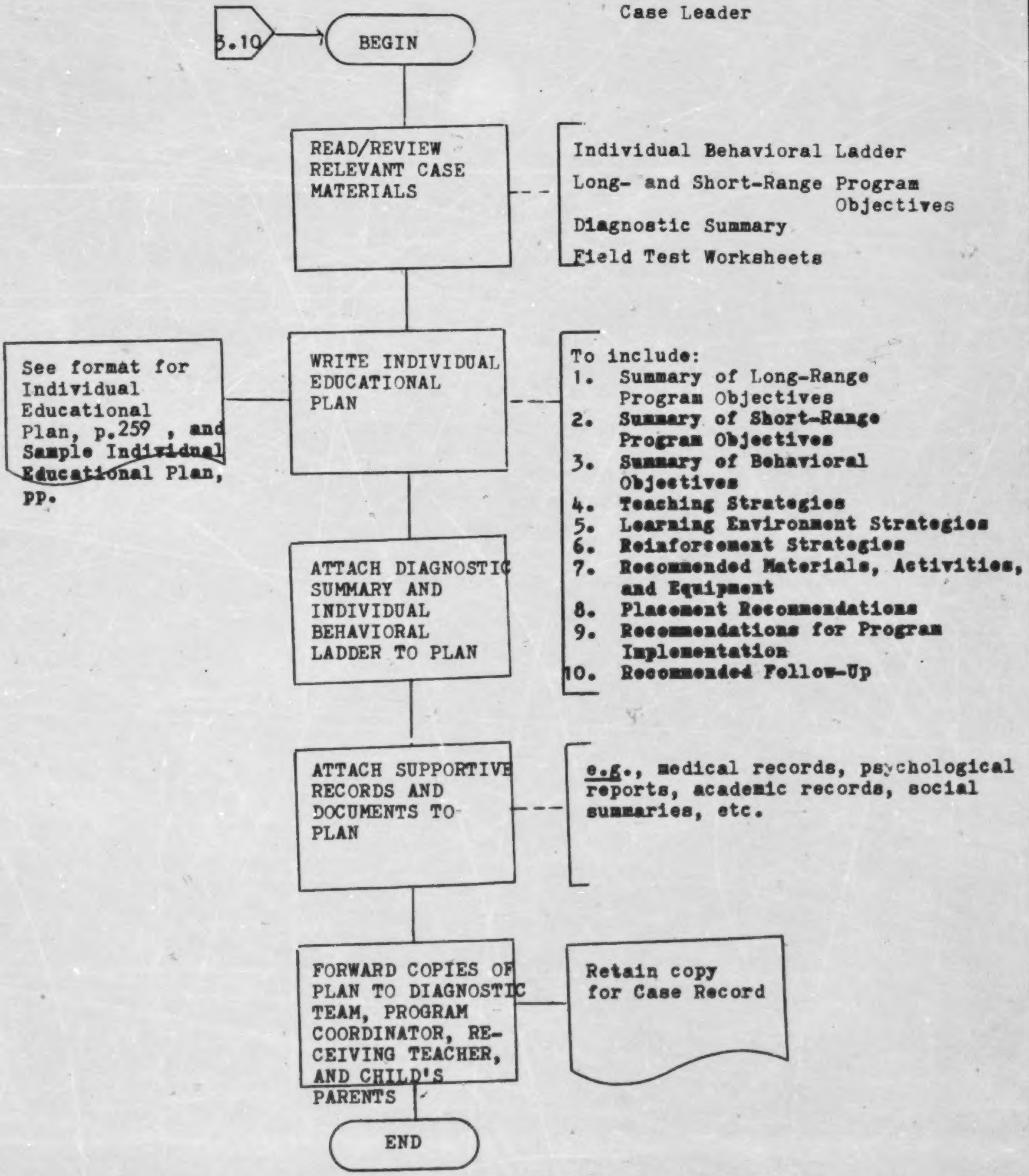

Case Leader
Diagnostic Team
3.9
BEGIN
CONSULT WITH DIAGNOSTIC TEAM AS NECESSARY
See
2.7
DISCUSS/DETERMINE/ MAKE NOTE OF NEED FOR FOLLOW-UP CONSULTATION AND ASSISTANCE BY DIAGNOSTIC TEAM
DISCUSS/DETERMINE/ MAKE NOTE OF POST-PLACEMENT DATA COLLECTION REQUIRED
i.e., observation, formal and informal testing, grades, psychological work-ups, and medical testing, etc.--for comparison to pre-placement data (see Chart 5.5)
DISCUSS/DETERMINE/ MAKE NOTE OF REQUIRED FOLLOW-UP SOCIAL SERVICES
MAKE NOTE OF DATES FOR INFORMAL AND FORMAL EVALUATION
i.e., 1, 3, 6, 9, and 12 months after child's exit. See charts 5.3, 5.4, and 5.6
ENTER DATES FOR FOLLOW-UP SERVICES, DATA COLLECTION, AND FORMAL AND INFORMAL EVALUATION IN TICKLER FILE
See Follow-Up Form, p. 165
END

Chart 3.10 WRITE INDIVIDUAL EDUCATIONAL PLAN


Case Leader
3.10
BEGIN
READ/REVIEW RELEVANT CASE MATERIALS
Individual Behavioral Ladder
Long- and Short-Range Program Objectives
Diagnostic Summary
Field Test Worksheets
See format for Individual Educational Plan, p.259 , and Sample Individual Educational Plan, pp.
WRITE INDIVIDUAL EDUCATIONAL PLAN
To include:
1. Summary of Long-Range Program Objectives
2. Summary of Short-Range Program Objectives
3. Summary of Behavioral Objectives
4. Teaching Strategies
5. Learning Environment Strategies
6. Reinforcement Strategies
7. Recommended Materials, Activities, and Equipment
8. Placement Recommendations
9. Recommendations for Program Implementation
10. Recommended Follow-Up
ATTACH DIAGNOSTIC SUMMARY AND INDIVIDUAL BEHAVIORAL LADDER TO PLAN
ATTACH SUPPORTIVE RECORDS AND DOCUMENTS TO PLAN
e.g., medical records, psychological reports, academic records, social summaries, etc.
FORWARD COPIES OF PLAN TO DIAGNOSTIC TEAM, PROGRAM COORDINATOR, RECEIVING TEACHER, AND CHILD'S PARENTS
Retain copy for Case Record
END

Phase 4: TRANSITION

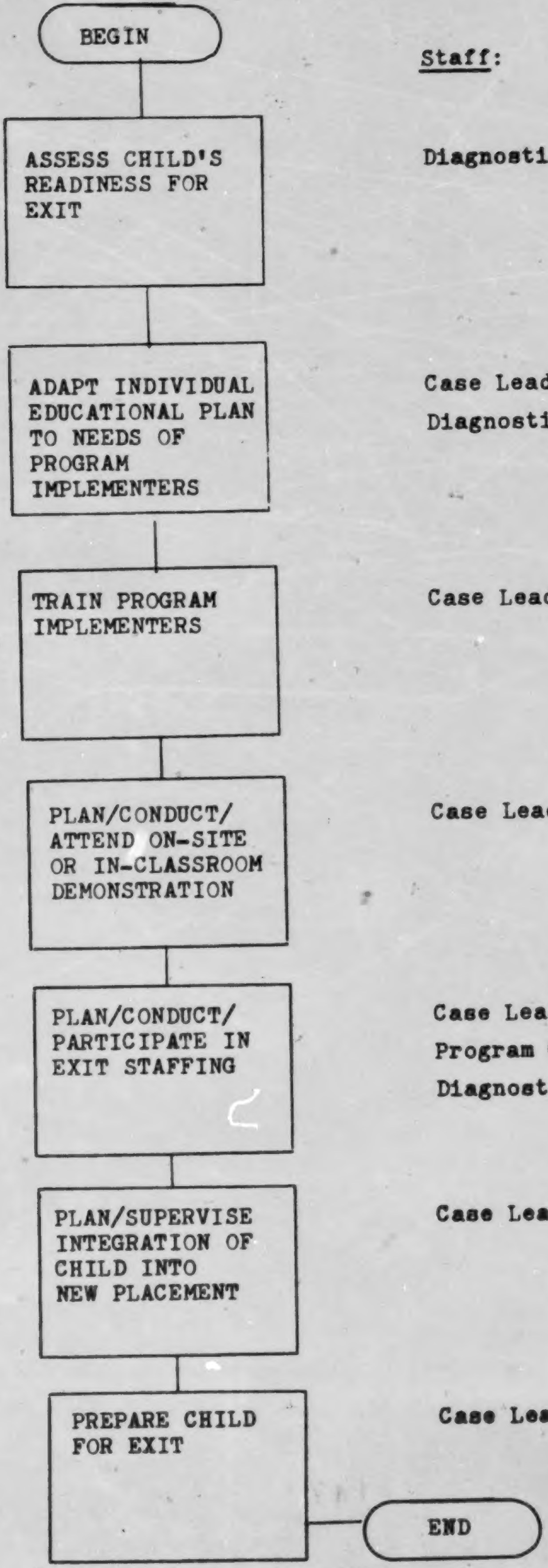
Objectives:

1. To prepare the child for exit.
2. To adapt the Individual Educational Plan to the resources and constraints of the receiving school.
3. To train the child's parents and current or receiving teacher in program implementation.
4. To supervise the child's integration into his or her new placement.

Initiating Event: Program finalization and placement decision.

Terminating Event: Exit of child from Diagnostic Classroom or termination of on-site services.

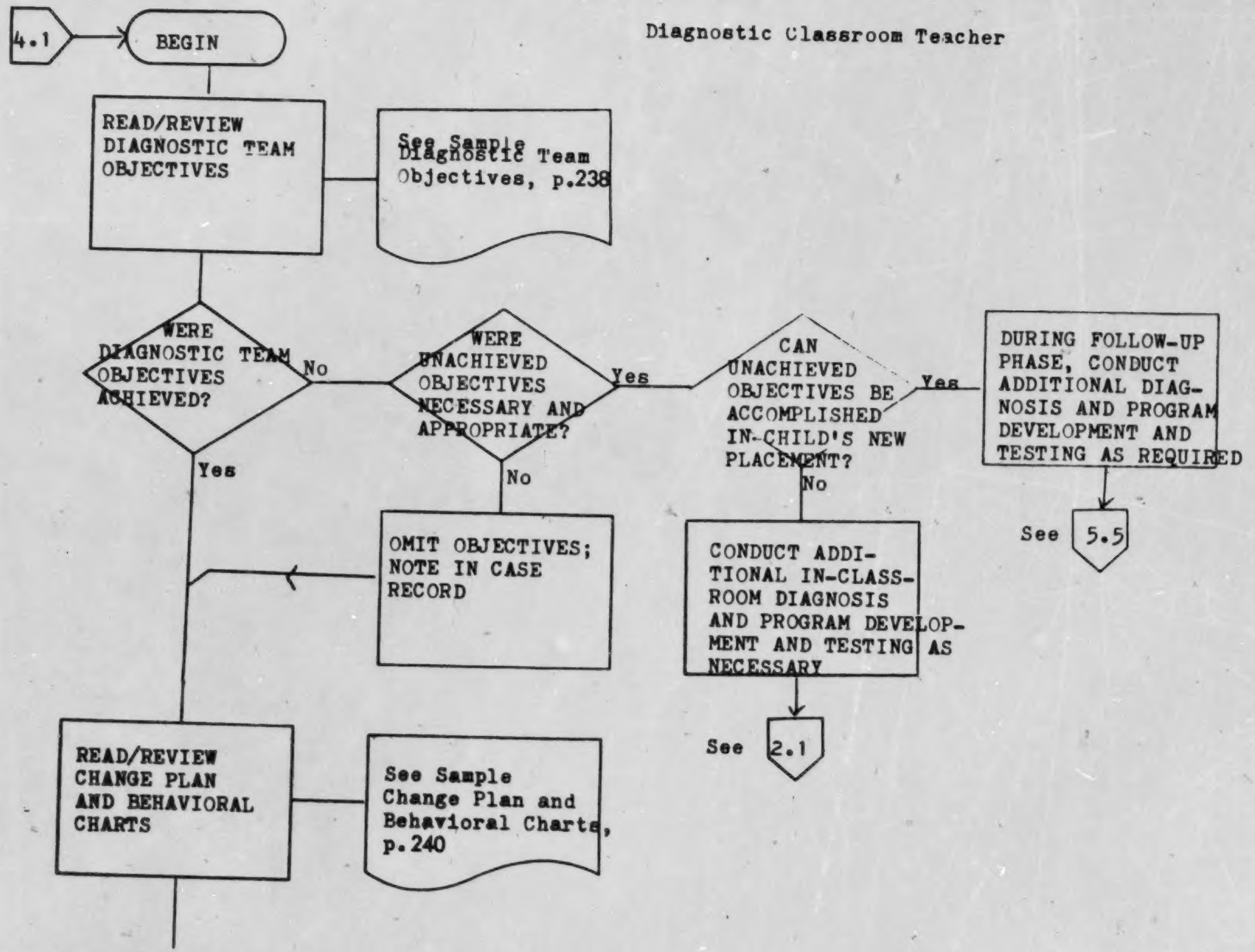
OVERVIEW OF PHASE 4: TRANSITION


BEGIN
ASSESS CHILD'S READINESS FOR EXIT
ADAPT INDIVIDUAL EDUCATIONAL PLAN TO NEEDS OF PROGRAM IMPLEMENTERS
TRAIN PROGRAM IMPLEMENTERS
PLAN/CONDUCT/ ATTEND ON-SITE OR IN-CLASSROOM DEMONSTRATION
PLAN/CONDUCT/ PARTICIPATE IN EXIT STAFFING
PLAN/SUPERVISE INTEGRATION OF CHILD INTO NEW PLACEMENT
PREPARE CHILD FOR EXIT
END

Cf:	Staff:
Chart 4.1	Diagnostic Classroom Teacher
Chart 4.2	Case Leader Diagnostic Team
Chart 4.3	Case Leader
Chart 4.4	Case Leader
Chart 4.5	Case Leader Program Coordinator Diagnostic Team
Chart 4.6	Case Leader
Chart 4.7	Case Leader

Chart 4.1 ASSESS CHILD'S READINESS FOR EXIT (In-Classroom Only)

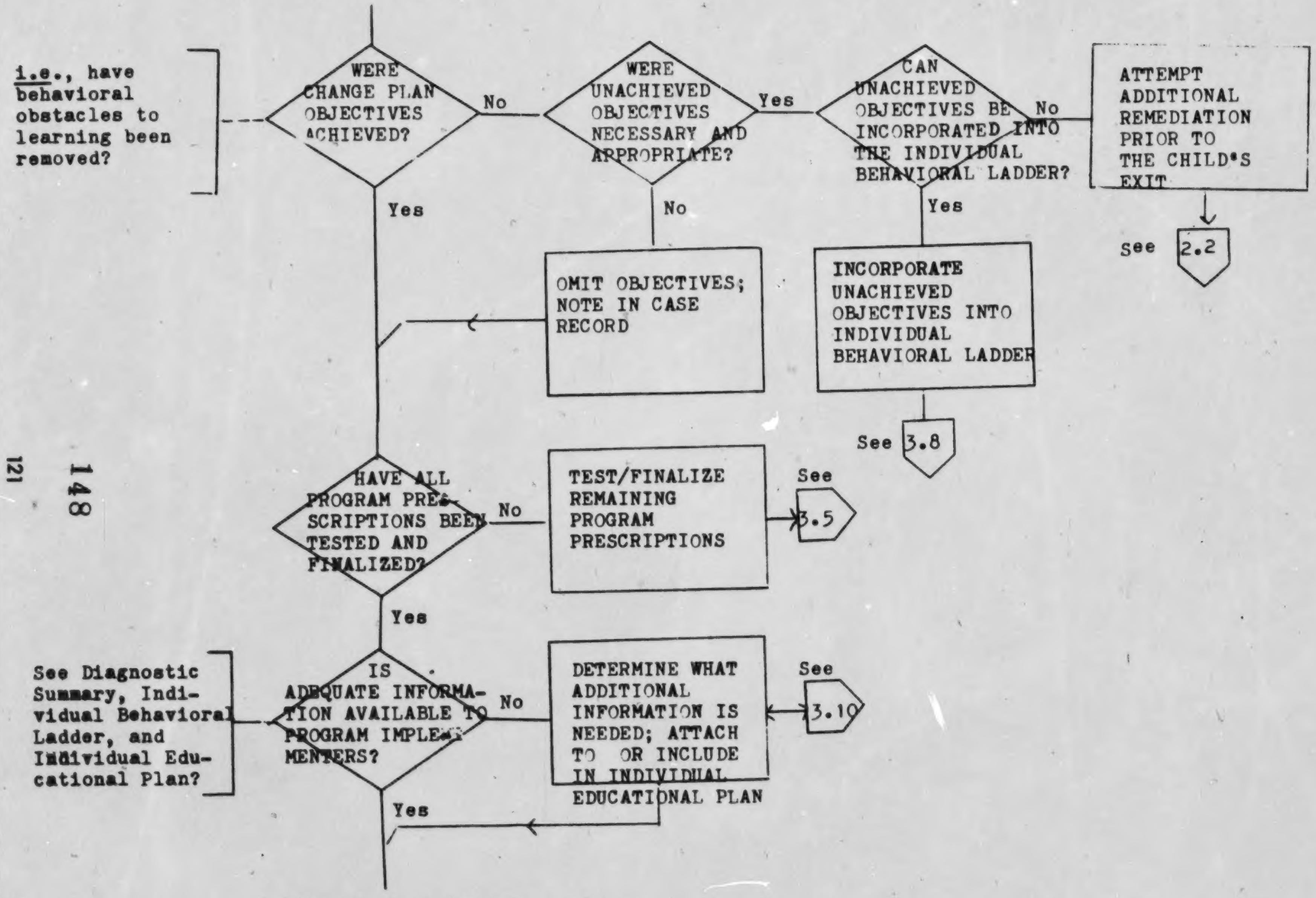
Diagnostic Classroom Teacher


4.1
BEGIN
READ/REVIEW DIAGNOSTIC TEAM OBJECTIVES
See Sample Diagnostic Team Objectives, p.238
WERE DIAGNOSTIC TEAM OBJECTIVES ACHIEVED?
No
Yes
WERE UNACHIEVED OBJECTIVES NECESSARY AND APPROPRIATE?
Yes
No
OMIT OBJECTIVES; NOTE IN CASE RECORD
CAN UNACHIEVED OBJECTIVES BE ACCOMPLISHED IN CHILD'S NEW PLACEMENT?
Yes
No
DURING FOLLOW-UP PHASE, CONDUCT ADDITIONAL DIAGNOSIS AND PROGRAM DEVELOPMENT AND TESTING AS REQUIRED
See
5.5
CONDUCT ADDITIONAL IN-CLASSROOM DIAGNOSIS AND PROGRAM DEVELOPMENT AND TESTING AS NECESSARY
See
2.1
READ/REVIEW CHANGE PLAN AND BEHAVIORAL CHARTS
See Sample Change Plan and Behavioral Charts, p.240

Continued on next page

Page one of three

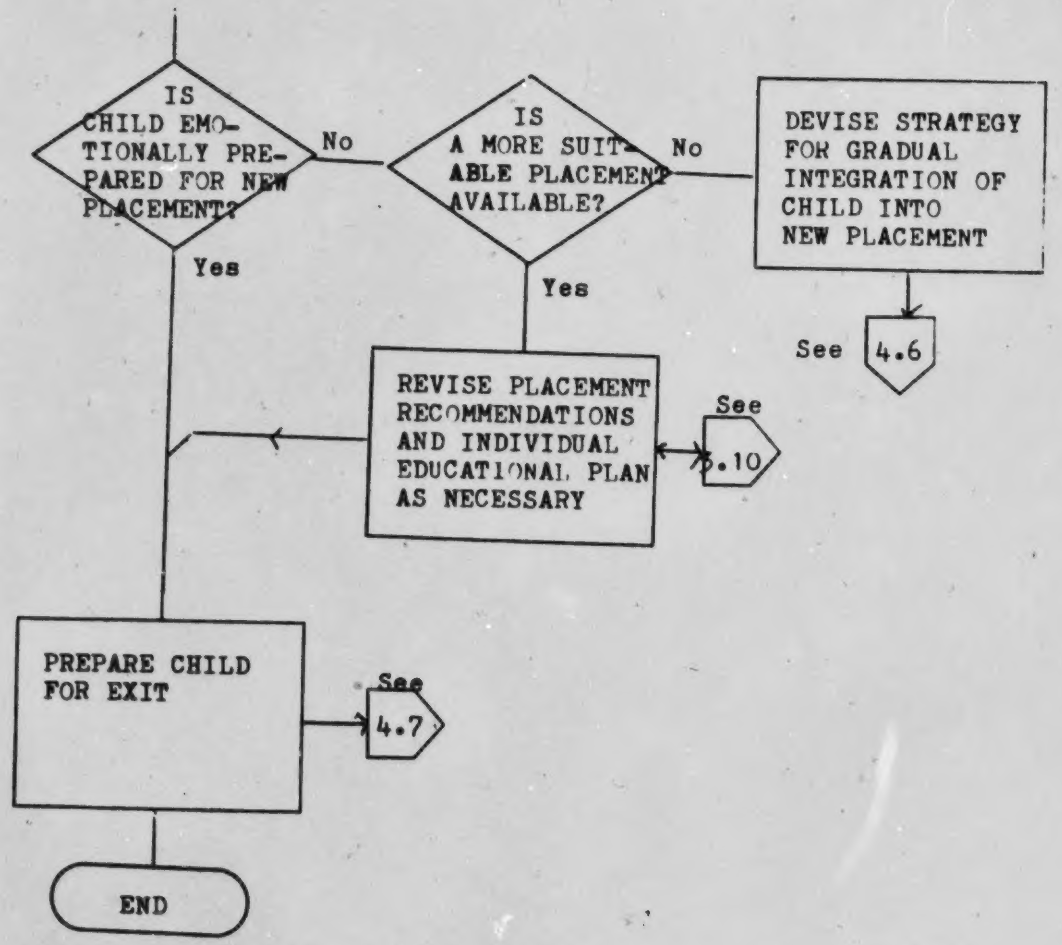
Chart 4.1 Continued


i.e., have behavioral obstacles to learning been removed?
WERE CHANGE PLAN OBJECTIVES ACHIEVED?
No
WERE UNACHIEVED OBJECTIVES NECESSARY AND APPROPRIATE?
Yes
CAN UNACHIEVED OBJECTIVES BE INCORPORATED INTO THE INDIVIDUAL BEHAVIORAL LADDER?
No
ATTEMPT ADDITIONAL REMEDIATION PRIOR TO THE CHILD'S EXIT
See 2.2
Yes
No
Yes
OMIT OBJECTIVES; NOTE IN CASE RECORD
INCORPORATE UNACHIEVED OBJECTIVES INTO INDIVIDUAL BEHAVIORAL LADDER
See 3.8
HAVE ALL PROGRAM PRESCRIPTIONS BEEN TESTED AND FINALIZED?
No
TEST/FINALIZE REMAINING PROGRAM PRESCRIPTIONS
See 3.5
Yes
See Diagnostic Summary, Individual Behavioral Ladder, and Individual Educational Plan?
IS ADEQUATE INFORMATION AVAILABLE TO PROGRAM IMPLEMENTERS?
No
DETERMINE WHAT ADDITIONAL INFORMATION IS NEEDED; ATTACH TO OR INCLUDE IN INDIVIDUAL EDUCATIONAL PLAN
See 3.10
Yes

Continued on next page

Page two of three

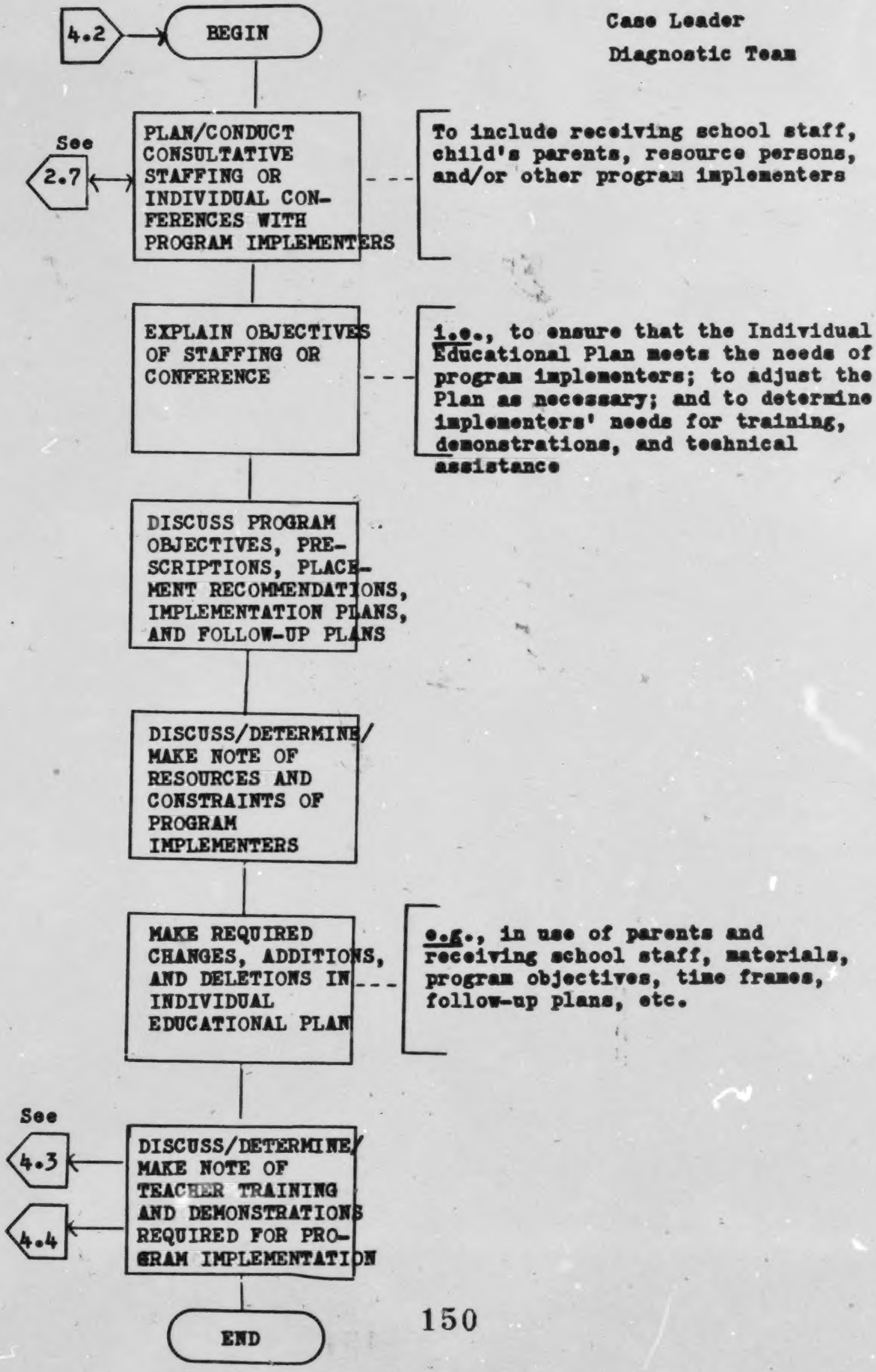
Chart 4.1 Continued


IS CHILD EMOTIONALLY PREPARED FOR NEW PLACEMENT?
No
Yes
IS A MORE SUITABLE PLACEMENT AVAILABLE?
No
Yes
DEVISE STRATEGY FOR GRADUAL INTEGRATION OF CHILD INTO NEW PLACEMENT
See 4.6
REVISE PLACEMENT RECOMMENDATIONS AND INDIVIDUAL EDUCATIONAL PLAN AS NECESSARY
See 3.10
PREPARE CHILD FOR EXIT
See 4.7
END

Page three of three

Case Leader

Diagnostic Team

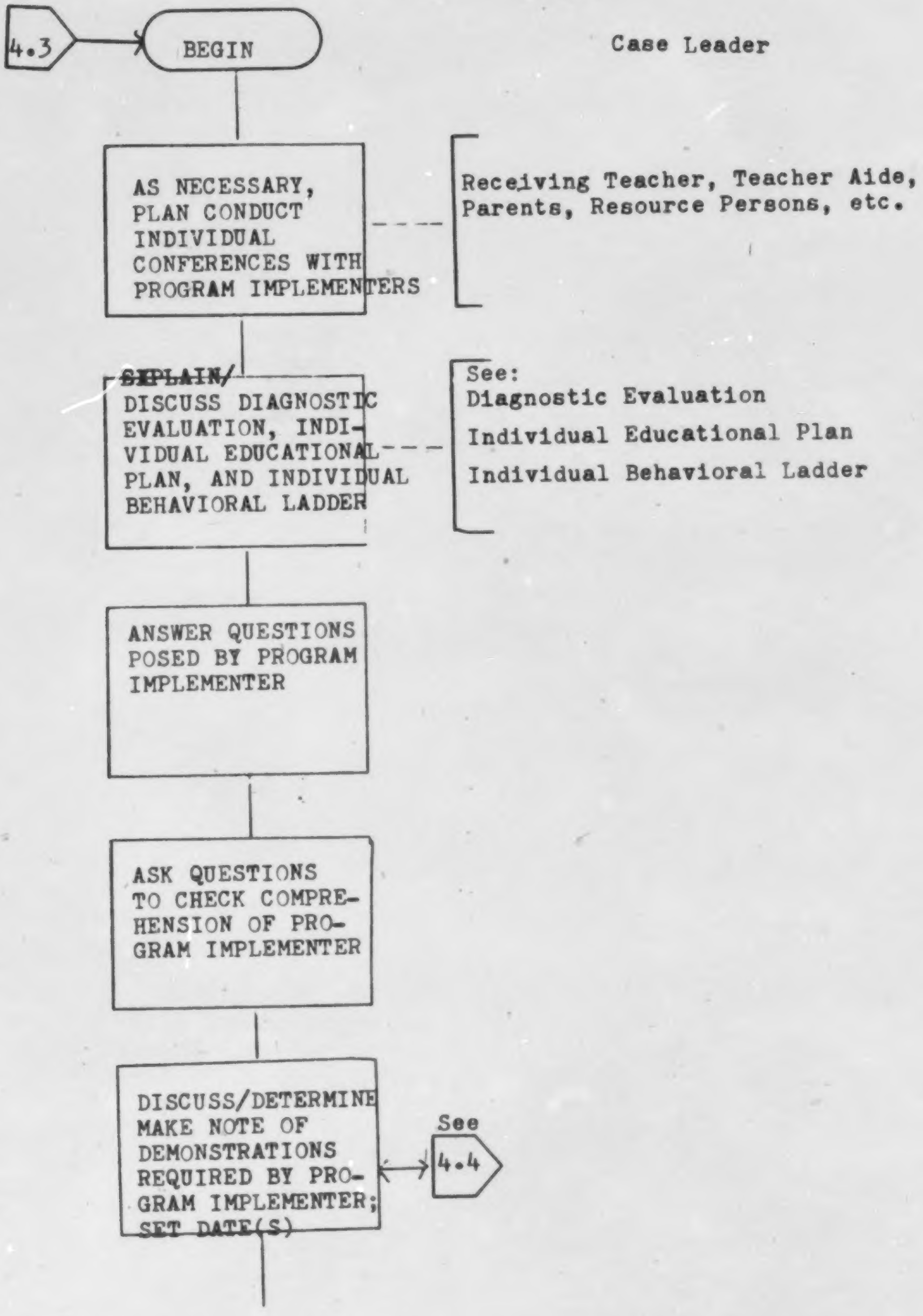

4.2
BEGIN
See
2.7
PLAN/CONDUCT CONSULTATIVE STAFFING OR INDIVIDUAL CONFERENCES WITH PROGRAM IMPLEMENTERS
EXPLAIN OBJECTIVES OF STAFFING OR CONFERENCE
DISCUSS PROGRAM OBJECTIVES, PRESCRIPTIONS, PLACEMENT RECOMMENDATIONS, IMPLEMENTATION PLANS, AND FOLLOW-UP PLANS
DISCUSS/DETERMINE/ MAKE NOTE OF RESOURCES AND CONSTRAINTS OF PROGRAM IMPLEMENTERS
MAKE REQUIRED CHANGES, ADDITIONS, AND DELETIONS IN INDIVIDUAL EDUCATIONAL PLAN
See
4.3
4.4
DISCUSS/DETERMINE/ MAKE NOTE OF TEACHER TRAINING AND DEMONSTRATIONS REQUIRED FOR PROGRAM IMPLEMENTATION
END

To include receiving school staff, child's parents, resource persons, and/or other program implementers

i.e., to ensure that the Individual Educational Plan meets the needs of program implementers; to adjust the Plan as necessary; and to determine implementers' needs for training, demonstrations, and technical assistance

e.g., in use of parents and receiving school staff, materials, program objectives, time frames, follow-up plans, etc.

CHART 4.3 TRAIN PROGRAM IMPLEMENTERS


4.3
BEGIN
Case Leader
AS NECESSARY, PLAN CONDUCT INDIVIDUAL CONFERENCES WITH PROGRAM IMPLEMENTERS
Receiving Teacher, Teacher Aide, Parents, Resource Persons, etc.
~~EXPLAIN~~/ DISCUSS DIAGNOSTIC EVALUATION, INDIVIDUAL EDUCATIONAL PLAN, AND INDIVIDUAL BEHAVIORAL LADDER
See:
Diagnostic Evaluation
Individual Educational Plan
Individual Behavioral Ladder
ANSWER QUESTIONS POSED BY PROGRAM IMPLEMENTER
ASK QUESTIONS TO CHECK COMPREHENSION OF PROGRAM IMPLEMENTER
DISCUSS/DETERMINE MAKE NOTE OF DEMONSTRATIONS REQUIRED BY PROGRAM IMPLEMENTER; SET DATE(S)
See
4.4

Continued on next page

Page one of two

Chart 4.3 Continued

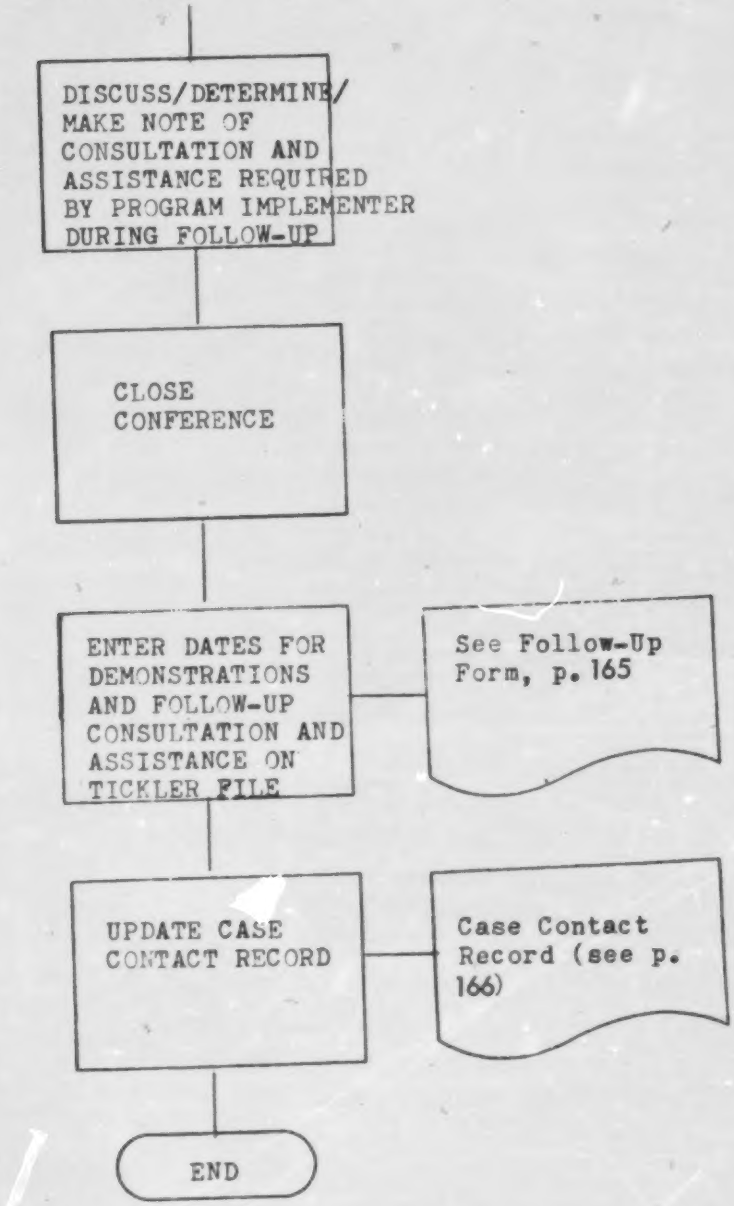
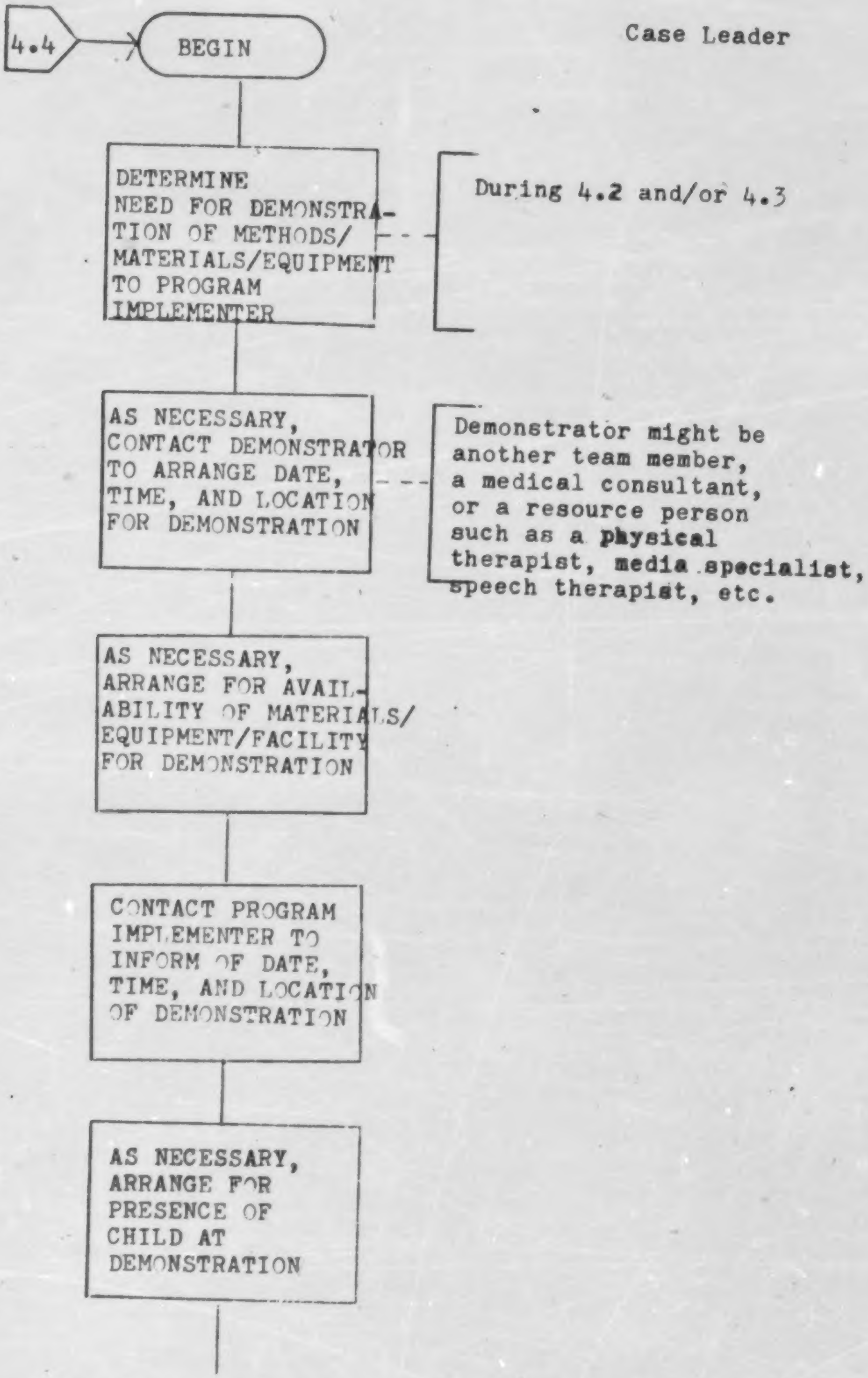

DISCUSS/DETERMINE/ MAKE NOTE OF CONSULTATION AND ASSISTANCE REQUIRED BY PROGRAM IMPLEMENTER DURING FOLLOW-UP
CLOSE CONFERENCE
ENTER DATES FOR DEMONSTRATIONS AND FOLLOW-UP CONSULTATION AND ASSISTANCE ON TICKLER FILE
See Follow-Up Form, p. 165
UPDATE CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

Chart 4.4 PLAN/CONDUCT/ATTEND ON-SITE OR IN-CLASSROOM DEMONSTRATION


4.4
BEGIN
DETERMINE NEED FOR DEMONSTRATION OF METHODS/ MATERIALS/EQUIPMENT TO PROGRAM IMPLEMENTER
AS NECESSARY, CONTACT DEMONSTRATOR TO ARRANGE DATE, TIME, AND LOCATION FOR DEMONSTRATION
AS NECESSARY, ARRANGE FOR AVAILABILITY OF MATERIALS/ EQUIPMENT/FACILITY FOR DEMONSTRATION
CONTACT PROGRAM IMPLEMENTER TO INFORM OF DATE, TIME, AND LOCATION OF DEMONSTRATION
AS NECESSARY, ARRANGE FOR PRESENCE OF CHILD AT DEMONSTRATION

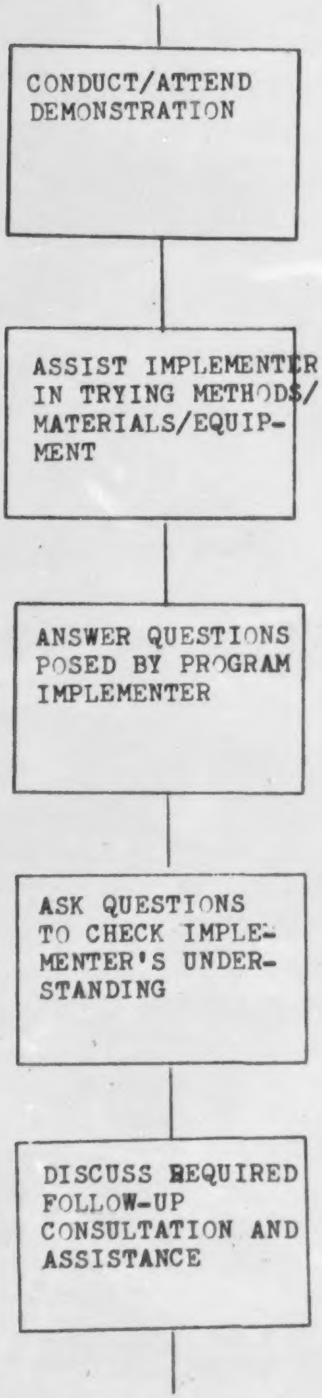
Case Leader

During 4.2 and/or 4.3

Demonstrator might be another team member, a medical consultant, or a resource person such as a physical therapist, media specialist, speech therapist, etc.

Continued on next page

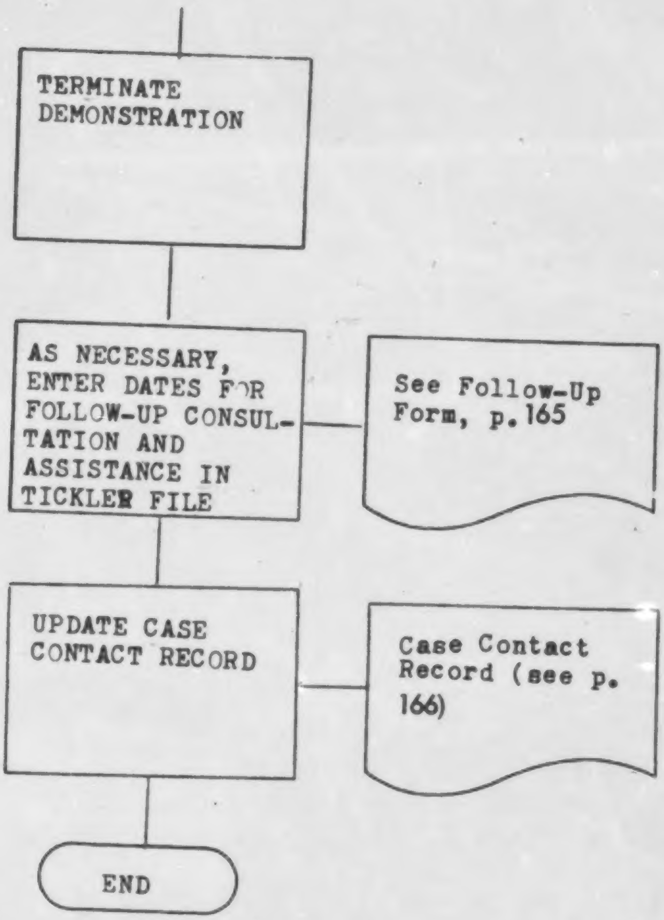
Chart 4.4 Continued


CONDUCT/ATTEND DEMONSTRATION
ASSIST IMPLEMENTER IN TRYING METHODS/ MATERIALS/EQUIPMENT
ANSWER QUESTIONS POSED BY PROGRAM IMPLEMENTER
ASK QUESTIONS TO CHECK IMPLEMENTER'S UNDERSTANDING
DISCUSS REQUIRED FOLLOW-UP CONSULTATION AND ASSISTANCE

Continued on next page

Page two of three

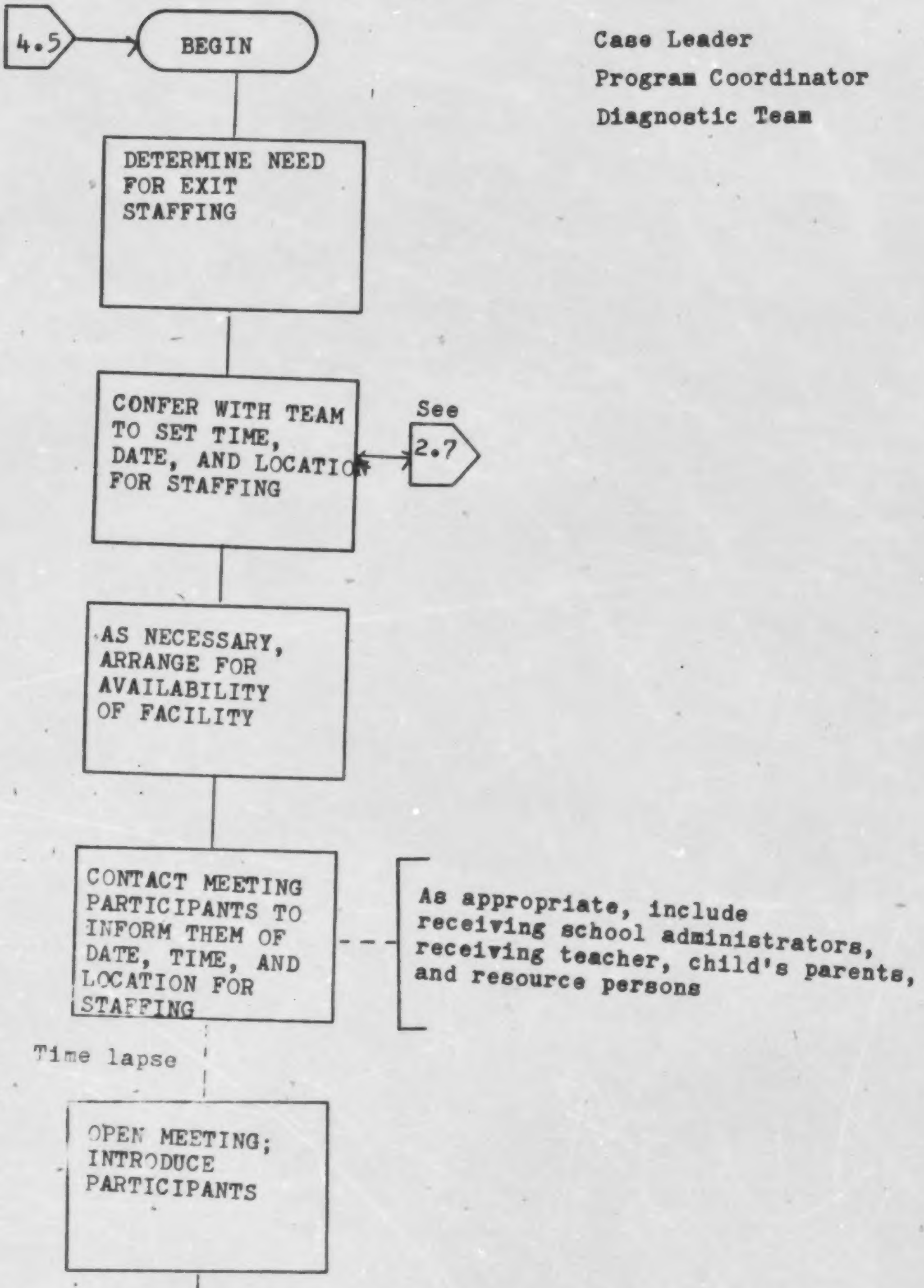
Chart 4.4 Continued


TERMINATE DEMONSTRATION
AS NECESSARY, ENTER DATES FOR FOLLOW-UP CONSULTATION AND ASSISTANCE IN TICKLER FILE
See Follow-Up Form, p. 165
UPDATE CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

Page three of three

Chart 4.5 PLAN/CONDUCT/PARTICIPATE IN EXIT STAFFING

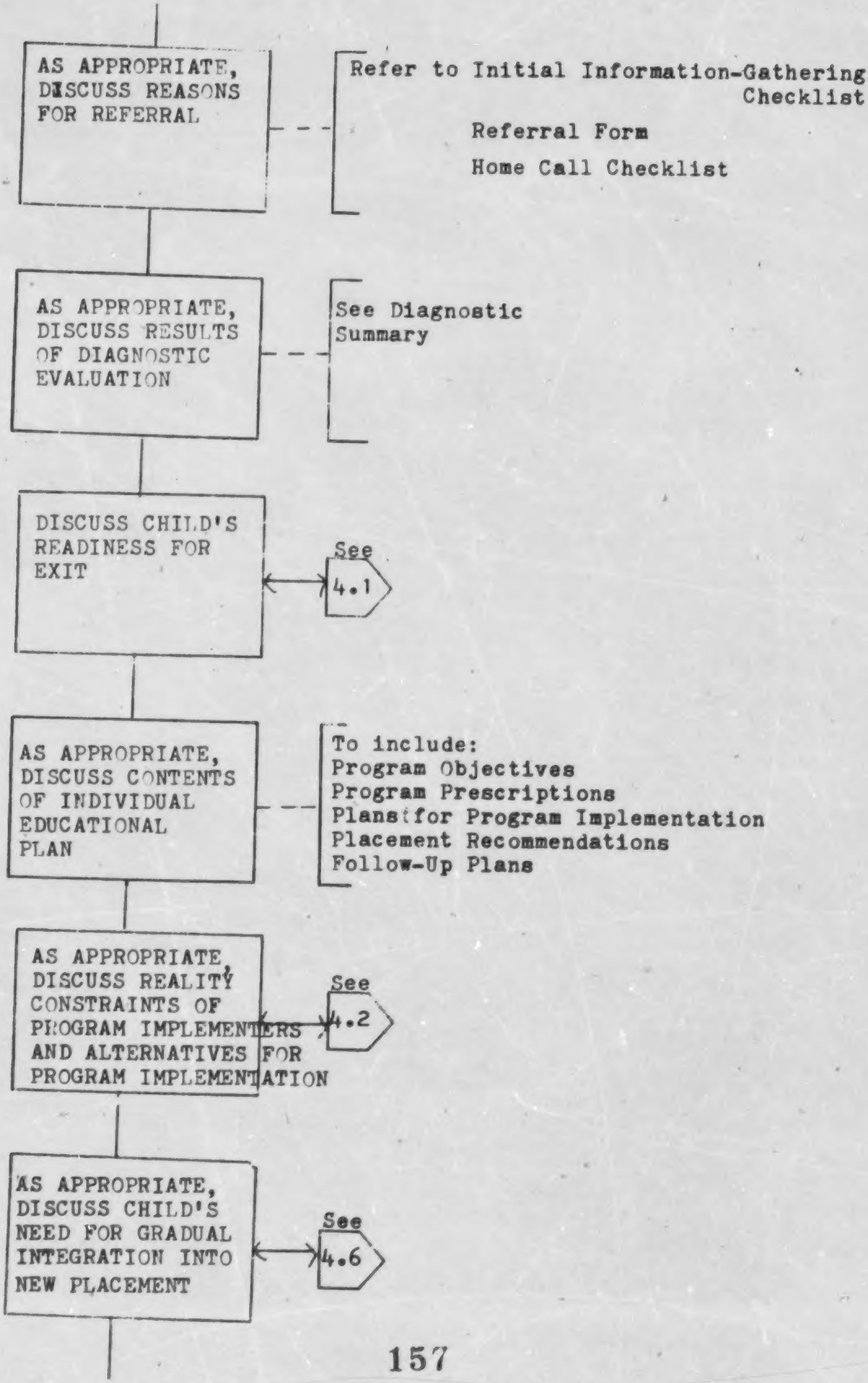
Case Leader
Program Coordinator
Diagnostic Team


4.5
BEGIN
DETERMINE NEED FOR EXIT STAFFING
CONFER WITH TEAM TO SET TIME, DATE, AND LOCATION FOR STAFFING
See
2.7
AS NECESSARY, ARRANGE FOR AVAILABILITY OF FACILITY
CONTACT MEETING PARTICIPANTS TO INFORM THEM OF DATE, TIME, AND LOCATION FOR STAFFING
As appropriate, include receiving school administrators, receiving teacher, child's parents, and resource persons
Time lapse
OPEN MEETING; INTRODUCE PARTICIPANTS

Continued on next page

Page one of three

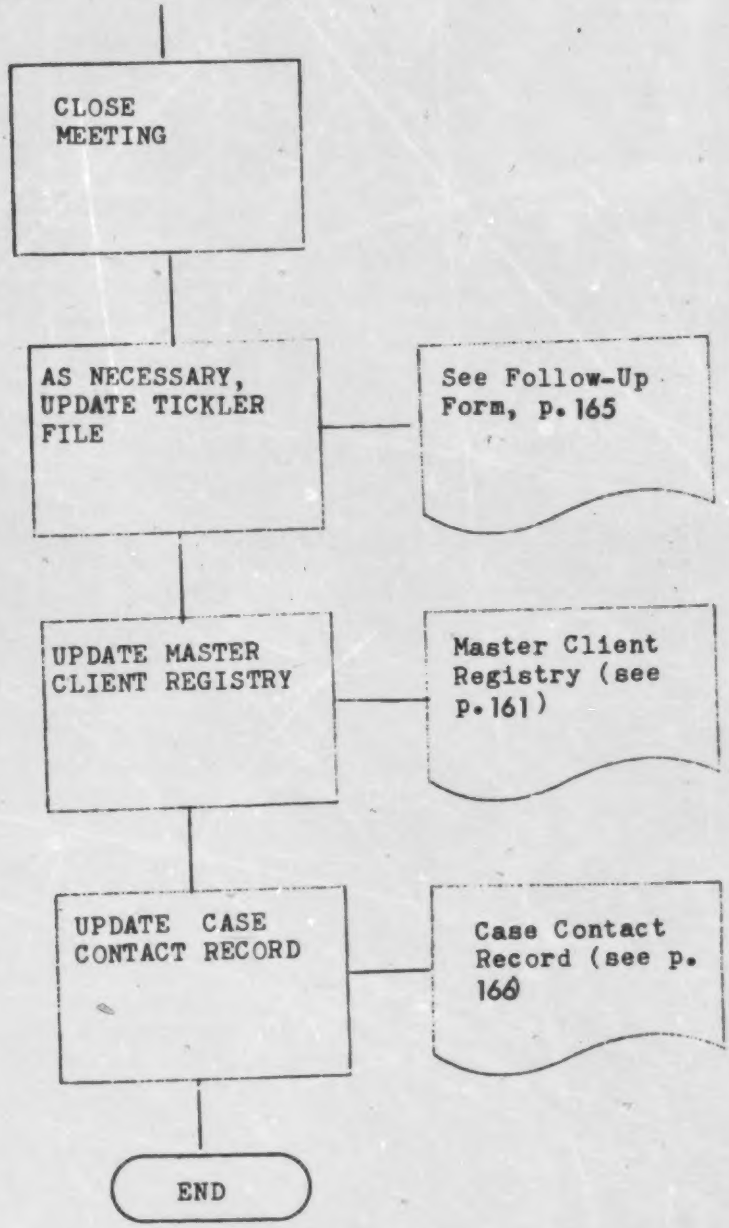
Chart 4.5 Continued


AS APPROPRIATE, DISCUSS REASONS FOR REFERRAL
Refer to Initial Information-Gathering Checklist
Referral Form
Home Call Checklist
AS APPROPRIATE, DISCUSS RESULTS OF DIAGNOSTIC EVALUATION
See Diagnostic Summary
DISCUSS CHILD'S READINESS FOR EXIT
See 4.1
AS APPROPRIATE, DISCUSS CONTENTS OF INDIVIDUAL EDUCATIONAL PLAN
To include:
Program Objectives
Program Prescriptions
Plans for Program Implementation
Placement Recommendations
Follow-Up Plans
AS APPROPRIATE, DISCUSS REALITY CONSTRAINTS OF PROGRAM IMPLEMENTERS AND ALTERNATIVES FOR PROGRAM IMPLEMENTATION
See 4.2
AS APPROPRIATE, DISCUSS CHILD'S NEED FOR GRADUAL INTEGRATION INTO NEW PLACEMENT
See 4.6

Continued on next page

Page two of three

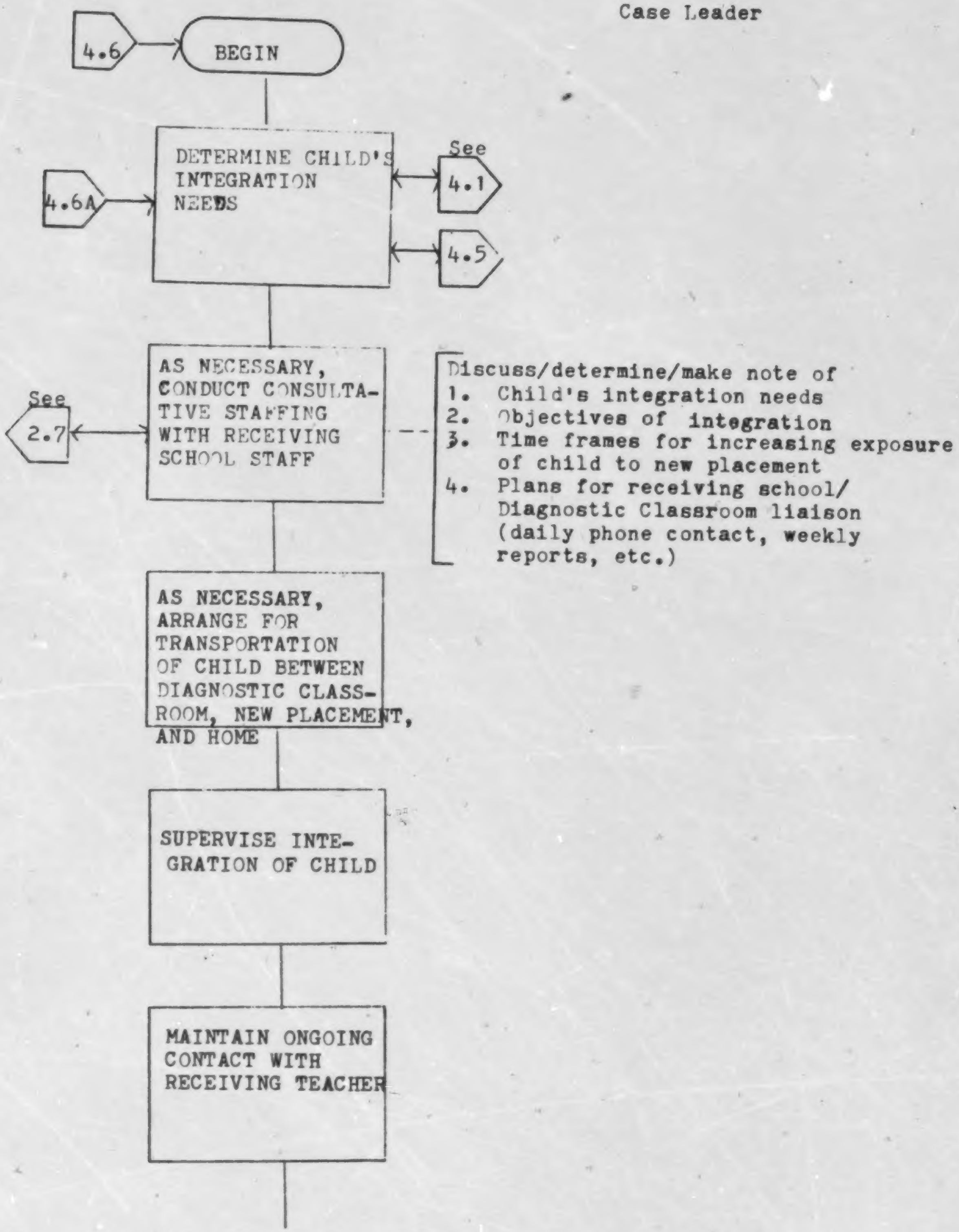
Chart 4.5 Continued


CLOSE MEETING
AS NECESSARY, UPDATE TICKLER FILE
See Follow-Up Form, p. 165
UPDATE MASTER CLIENT REGISTRY
Master Client Registry (see p. 161)
UPDATE CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

Page three of three

Chart 4.6 PLAN/SUPERVISE INTEGRATION OF CHILD INTO NEW PLACEMENT

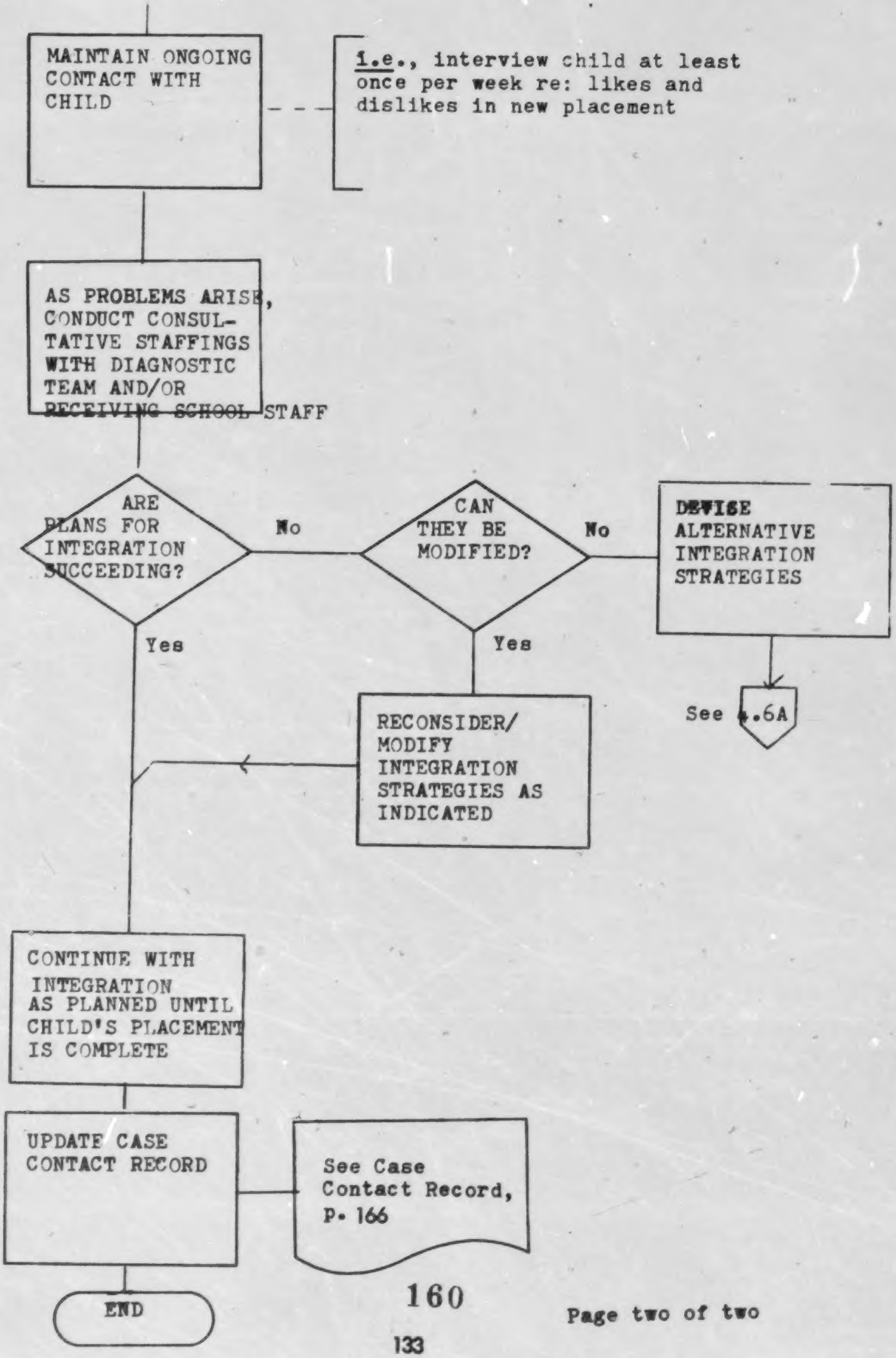
Case Leader


4.6
BEGIN
4.6A
DETERMINE CHILD'S INTEGRATION NEEDS
See
4.1
4.5
See
2.7
AS NECESSARY, CONDUCT CONSULTATIVE STAFFING WITH RECEIVING SCHOOL STAFF
AS NECESSARY, ARRANGE FOR TRANSPORTATION OF CHILD BETWEEN DIAGNOSTIC CLASSROOM, NEW PLACEMENT, AND HOME
SUPERVISE INTEGRATION OF CHILD
MAINTAIN ONGOING CONTACT WITH RECEIVING TEACHER

Discuss/determine/make note of
1. Child's integration needs
2. Objectives of integration
3. Time frames for increasing exposure of child to new placement
4. Plans for receiving school/ Diagnostic Classroom liaison (daily phone contact, weekly reports, etc.)

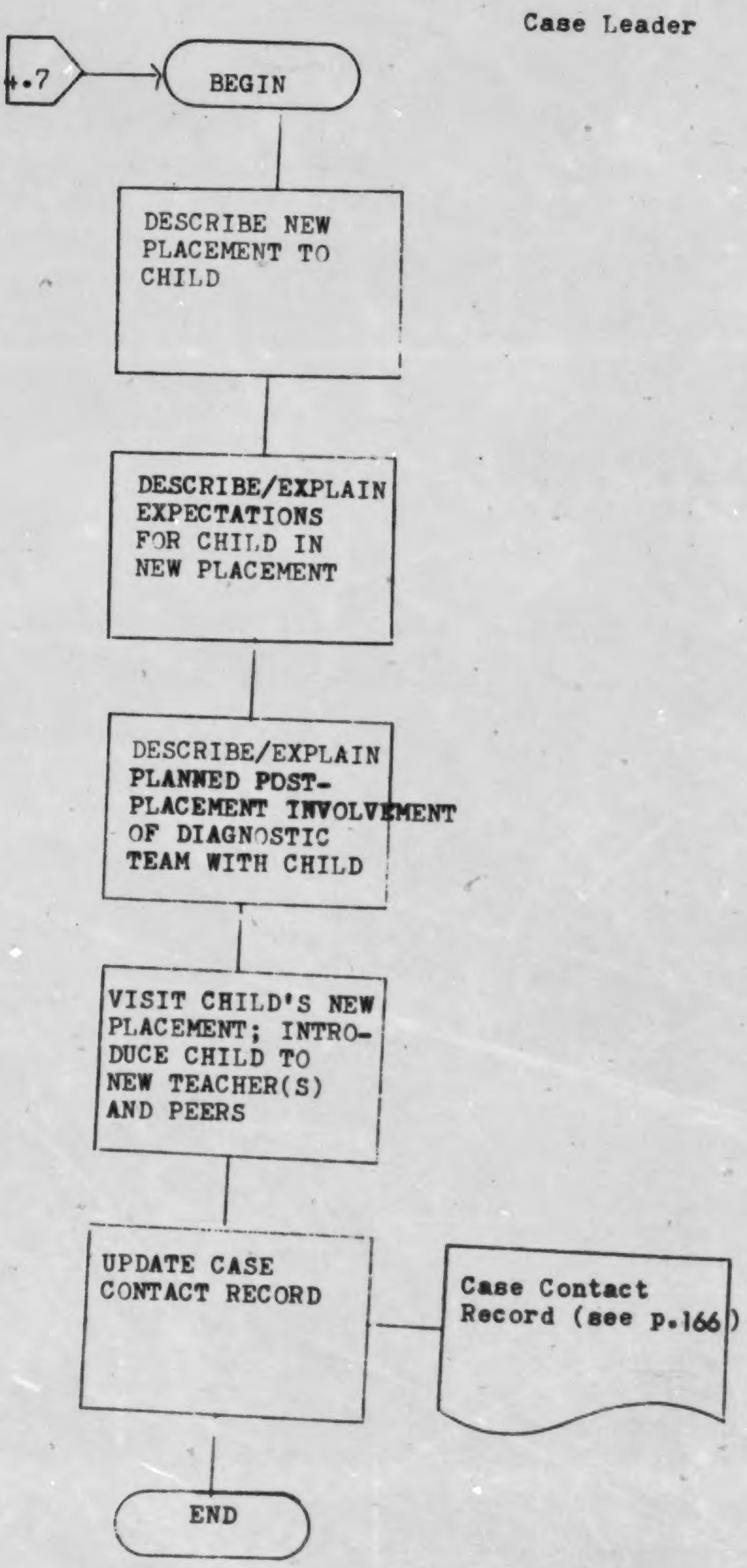
Continued on next page

Chart 4.6 Continued


MAINTAIN ONGOING CONTACT WITH CHILD
i.e., interview child at least once per week re: likes and dislikes in new placement
AS PROBLEMS ARISE, CONDUCT CONSULTATIVE STAFFINGS WITH DIAGNOSTIC TEAM AND/OR RECEIVING SCHOOL STAFF
ARE PLANS FOR INTEGRATION SUCCEEDING?
No
CAN THEY BE MODIFIED?
No
DEVISE ALTERNATIVE INTEGRATION STRATEGIES
See 4.6A
Yes
Yes
RECONSIDER/ MODIFY INTEGRATION STRATEGIES AS INDICATED
CONTINUE WITH INTEGRATION AS PLANNED UNTIL CHILD'S PLACEMENT IS COMPLETE
UPDATE CASE CONTACT RECORD
See Case Contact Record, P. 166
END

Page two of two

Chart 4.7 PREPARE CHILD FOR EXIT


Case Leader
4.7
BEGIN
DESCRIBE NEW PLACEMENT TO CHILD
DESCRIBE/EXPLAIN EXPECTATIONS FOR CHILD IN NEW PLACEMENT
DESCRIBE/EXPLAIN PLANNED POST-PLACEMENT INVOLVEMENT OF DIAGNOSTIC TEAM WITH CHILD
VISIT CHILD'S NEW PLACEMENT; INTRODUCE CHILD TO NEW TEACHER(S) AND PEERS
UPDATE CASE CONTACT RECORD
Case Contact Record (see p.166)
END

Phase 5: FOLLOW-UP

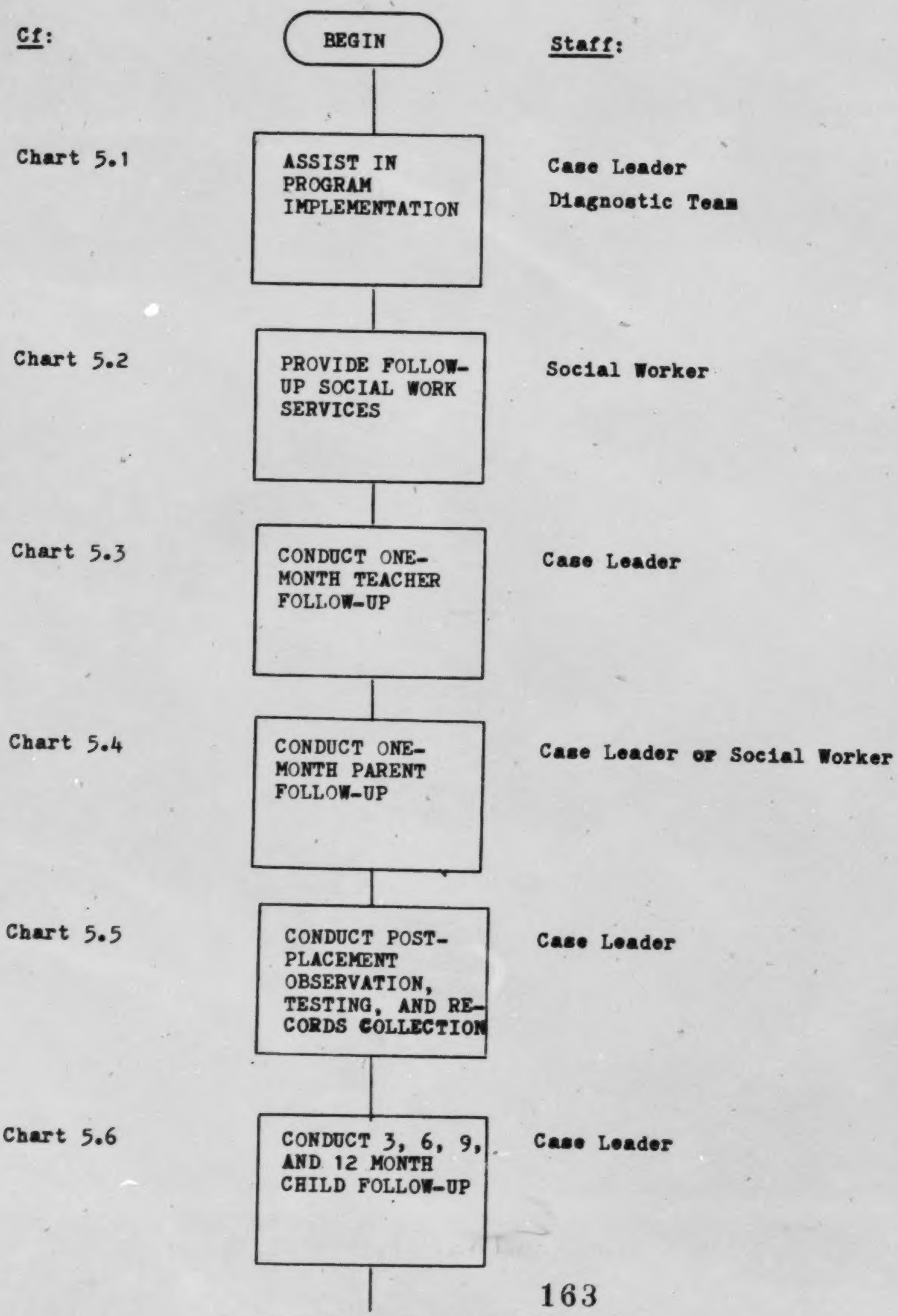
Objectives:

1. To assist in initial program implementation.
2. To provide post-placement consultation and assistance to the child's parents, teachers, and other program implementers.
3. To gather and analyze informal evaluation data for use in program evaluation and revision.
4. To gather and analyze formal evaluation data for use in the revision of the Individual Behavioral Ladder and in program evaluation and revision.

Initiating Event: Implementation of the Individual Educational Plan.

Terminating Event: Exit of the child from the educational system.

OVERVIEW OF PHASE 5: FOLLOW-UP


Cf:
BEGIN
Staff:
Chart 5.1
ASSIST IN PROGRAM IMPLEMENTATION
Case Leader
Diagnostic Team
Chart 5.2
PROVIDE FOLLOW-UP SOCIAL WORK SERVICES
Social Worker
Chart 5.3
CONDUCT ONE-MONTH TEACHER FOLLOW-UP
Case Leader
Chart 5.4
CONDUCT ONE-MONTH PARENT FOLLOW-UP
Case Leader or Social Worker
Chart 5.5
CONDUCT POST-PLACEMENT OBSERVATION, TESTING, AND RECORDS COLLECTION
Case Leader
Chart 5.6
CONDUCT 3, 6, 9, AND 12 MONTH CHILD FOLLOW-UP
Case Leader

Continued on next page

Phase 5 Overview Chart, Continued

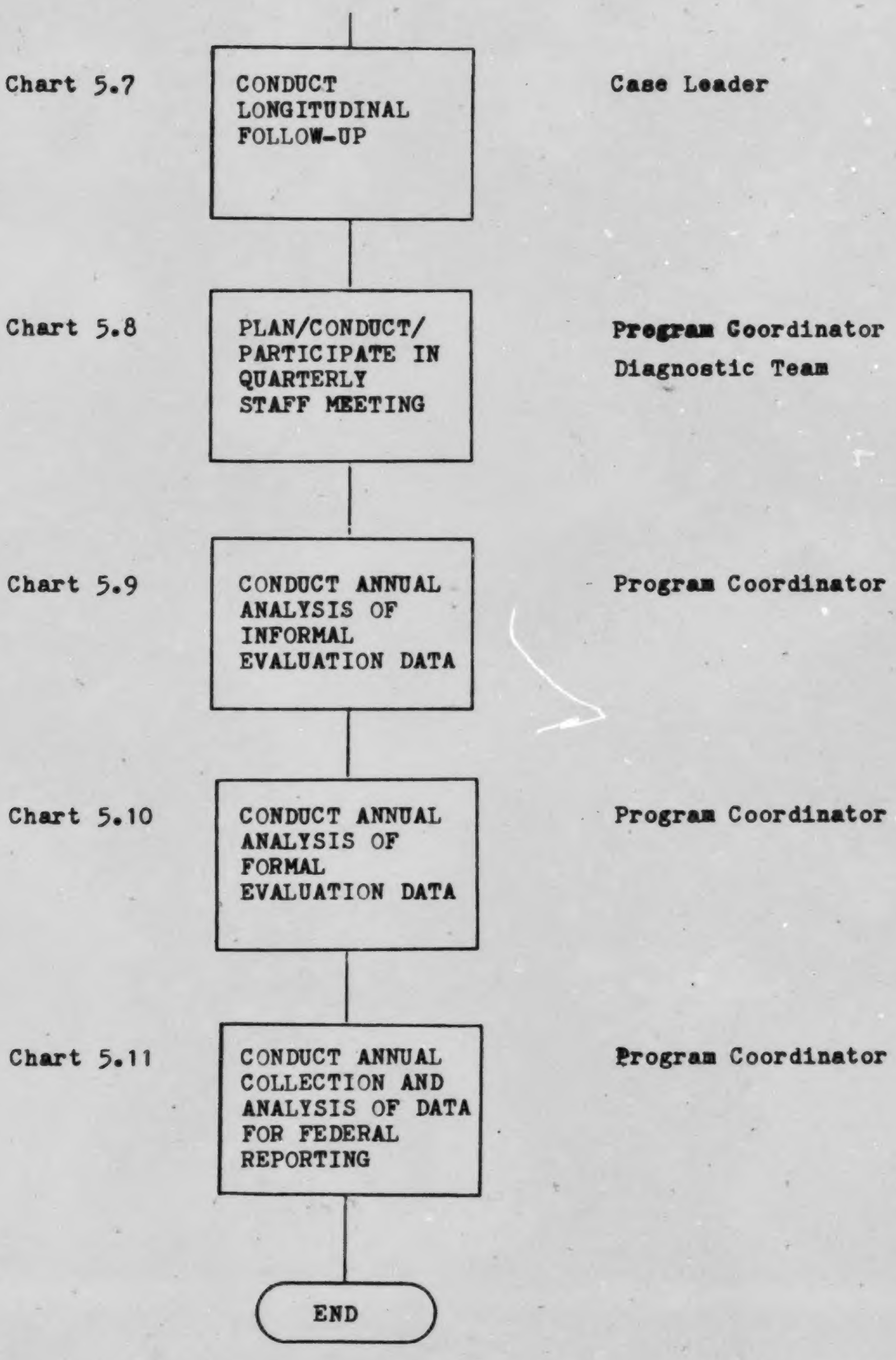


Chart 5.7
CONDUCT LONGITUDINAL FOLLOW-UP
Case Leader
Chart 5.8
PLAN/CONDUCT/ PARTICIPATE IN QUARTERLY STAFF MEETING
Program Coordinator
Diagnostic Team
Chart 5.9
CONDUCT ANNUAL ANALYSIS OF INFORMAL EVALUATION DATA
Program Coordinator
Chart 5.10
CONDUCT ANNUAL ANALYSIS OF FORMAL EVALUATION DATA
Program Coordinator
Chart 5.11
CONDUCT ANNUAL COLLECTION AND ANALYSIS OF DATA FOR FEDERAL REPORTING
Program Coordinator
END

Chart 5.1 ASSIST IN INITIAL PROGRAM IMPLEMENTATION

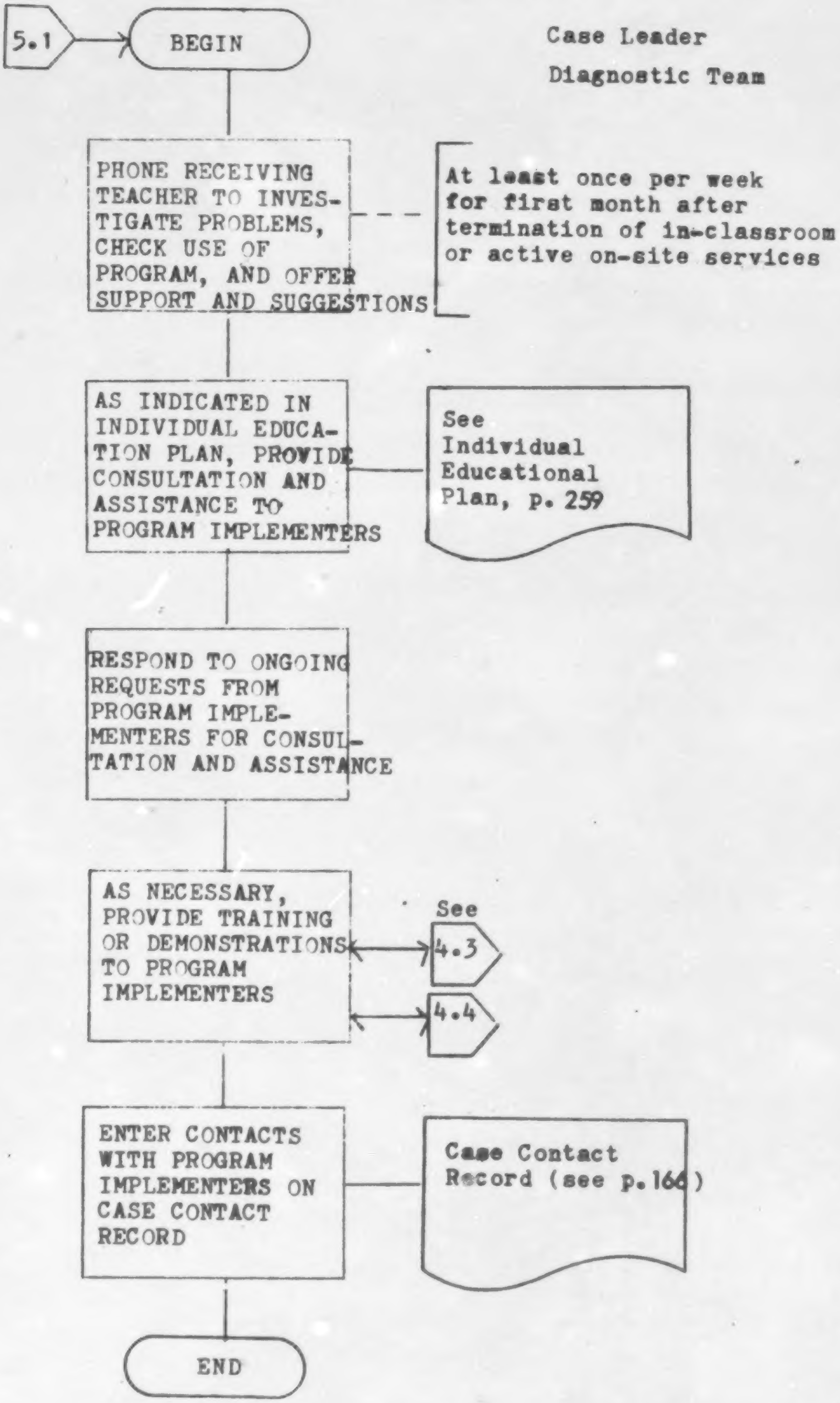
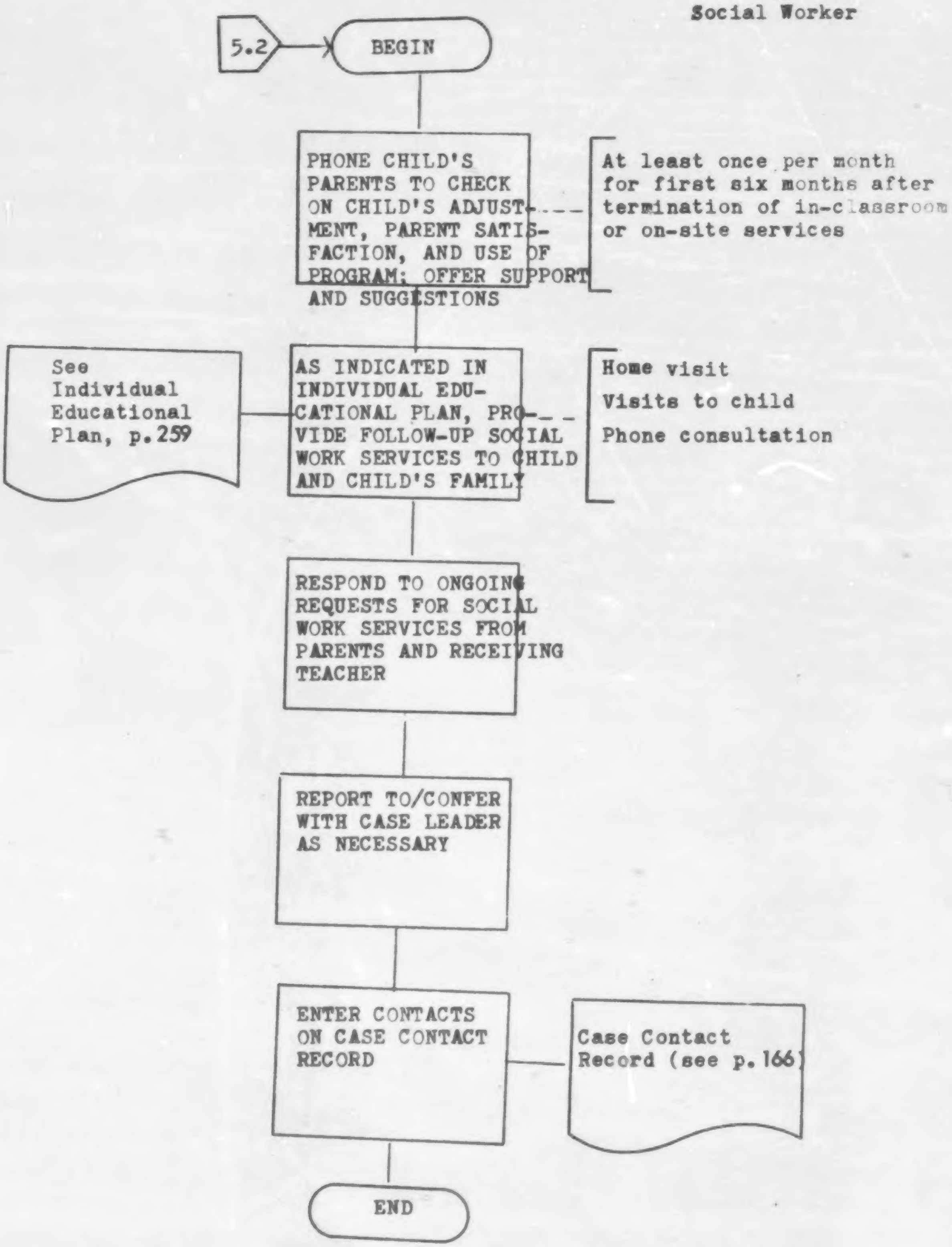
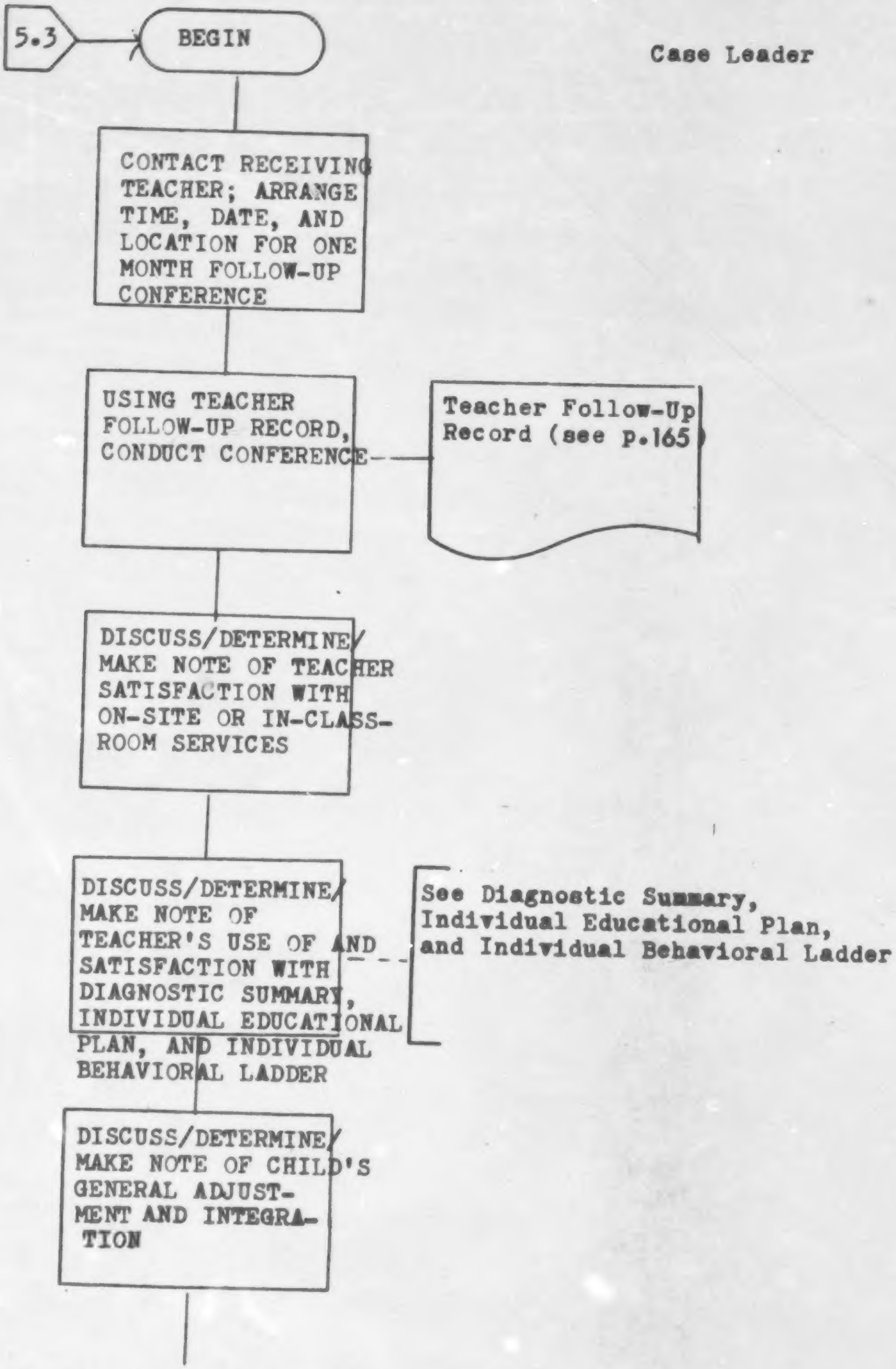

5.1
BEGIN
Case Leader
Diagnostic Team
PHONE RECEIVING TEACHER TO INVESTIGATE PROBLEMS, CHECK USE OF PROGRAM, AND OFFER SUPPORT AND SUGGESTIONS
At least once per week for first month after termination of in-classroom or active on-site services
AS INDICATED IN INDIVIDUAL EDUCATION PLAN, PROVIDE CONSULTATION AND ASSISTANCE TO PROGRAM IMPLEMENTERS
See Individual Educational Plan, p. 259
RESPOND TO ONGOING REQUESTS FROM PROGRAM IMPLEMENTERS FOR CONSULTATION AND ASSISTANCE
AS NECESSARY, PROVIDE TRAINING OR DEMONSTRATIONS TO PROGRAM IMPLEMENTERS
See
4.3
4.4
ENTER CONTACTS WITH PROGRAM IMPLEMENTERS ON CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

Chart 5.2 PROVIDE POST-PLACEMENT SOCIAL WORK SERVICES

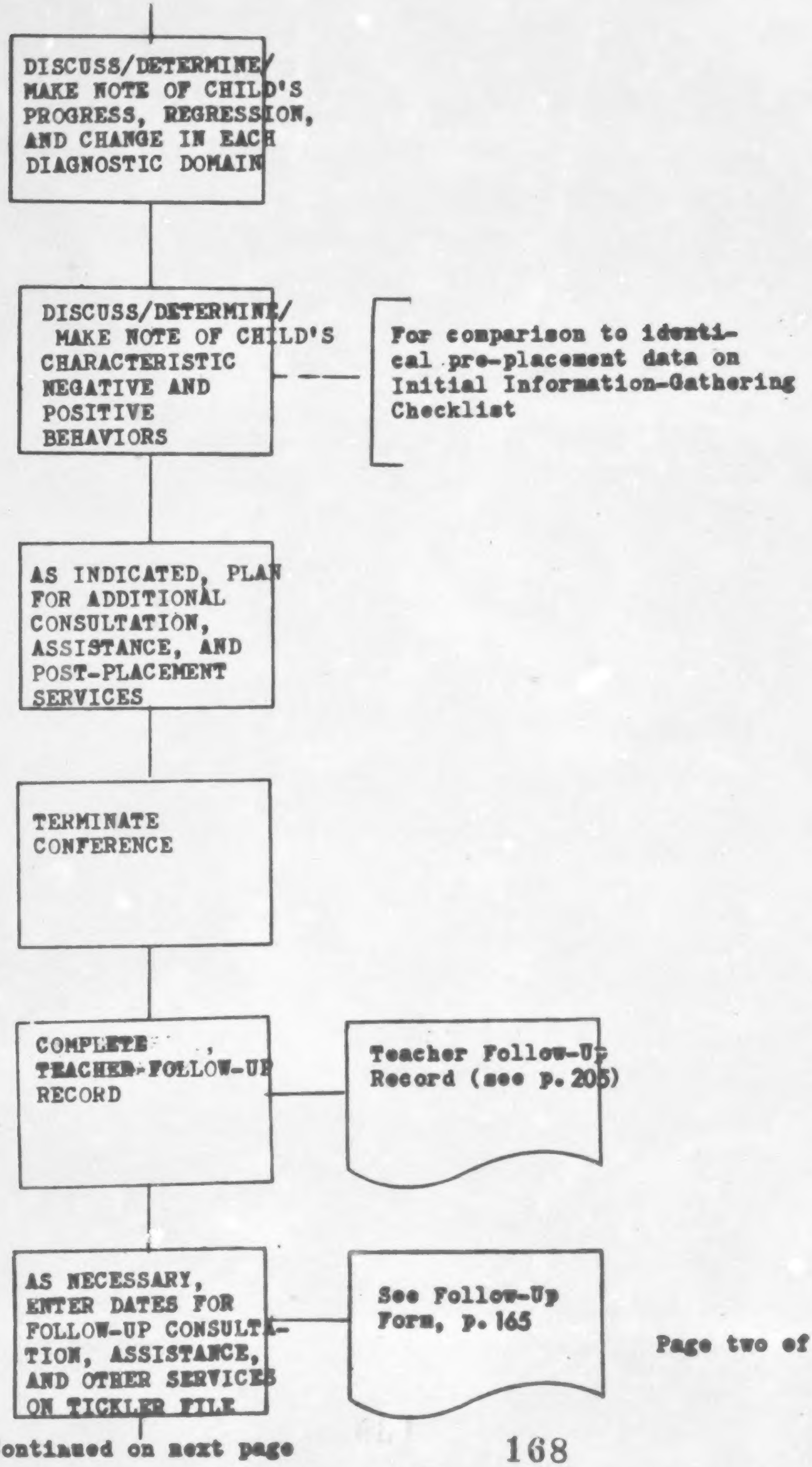

Social Worker
5.2
BEGIN
PHONE CHILD'S PARENTS TO CHECK ON CHILD'S ADJUSTMENT, PARENT SATISFACTION, AND USE OF PROGRAM; OFFER SUPPORT AND SUGGESTIONS
At least once per month for first six months after termination of in-classroom or on-site services
See Individual Educational Plan, p. 259
AS INDICATED IN INDIVIDUAL EDUCATIONAL PLAN, PROVIDE FOLLOW-UP SOCIAL WORK SERVICES TO CHILD AND CHILD'S FAMILY
Home visit
Visits to child
Phone consultation
RESPOND TO ONGOING REQUESTS FOR SOCIAL WORK SERVICES FROM PARENTS AND RECEIVING TEACHER
REPORT TO/CONFER WITH CASE LEADER AS NECESSARY
ENTER CONTACTS ON CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

5.3 CONDUCT ONE MONTH TEACHER FOLLOW-UP (Informal Evaluation)


5.3
BEGIN
Case Leader
CONTACT RECEIVING TEACHER; ARRANGE TIME, DATE, AND LOCATION FOR ONE MONTH FOLLOW-UP CONFERENCE
USING TEACHER FOLLOW-UP RECORD, CONDUCT CONFERENCE
Teacher Follow-Up Record (see p.165)
DISCUSS/DETERMINE/ MAKE NOTE OF TEACHER SATISFACTION WITH ON-SITE OR IN-CLASSROOM SERVICES
DISCUSS/DETERMINE/ MAKE NOTE OF TEACHER'S USE OF AND SATISFACTION WITH DIAGNOSTIC SUMMARY, INDIVIDUAL EDUCATIONAL PLAN, AND INDIVIDUAL BEHAVIORAL LADDER
See Diagnostic Summary, Individual Educational Plan, and Individual Behavioral Ladder
DISCUSS/DETERMINE/ MAKE NOTE OF CHILD'S GENERAL ADJUSTMENT AND INTEGRATION

Continued on next page

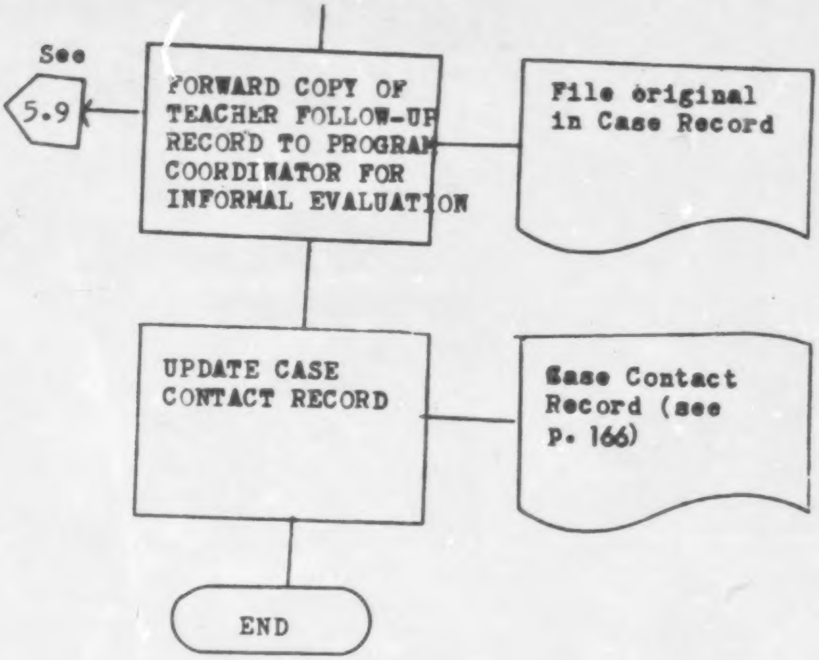
Chart 5.3 Continued


DISCUSS/DETERMINE/ MAKE NOTE OF CHILD'S PROGRESS, REGRESSION, AND CHANGE IN EACH DIAGNOSTIC DOMAIN
DISCUSS/DETERMINE/ MAKE NOTE OF CHILD'S CHARACTERISTIC NEGATIVE AND POSITIVE BEHAVIORS
For comparison to identical pre-placement data on Initial Information-Gathering Checklist
AS INDICATED, PLAN FOR ADDITIONAL CONSULTATION, ASSISTANCE, AND POST-PLACEMENT SERVICES
TERMINATE CONFERENCE
COMPLETE TEACHER-FOLLOW-UP RECORD
Teacher Follow-Up Record (see p. 205)
AS NECESSARY, ENTER DATES FOR FOLLOW-UP CONSULTATION, ASSISTANCE, AND OTHER SERVICES ON TICKLER FILE
See Follow-Up Form, p. 165

Page two of three

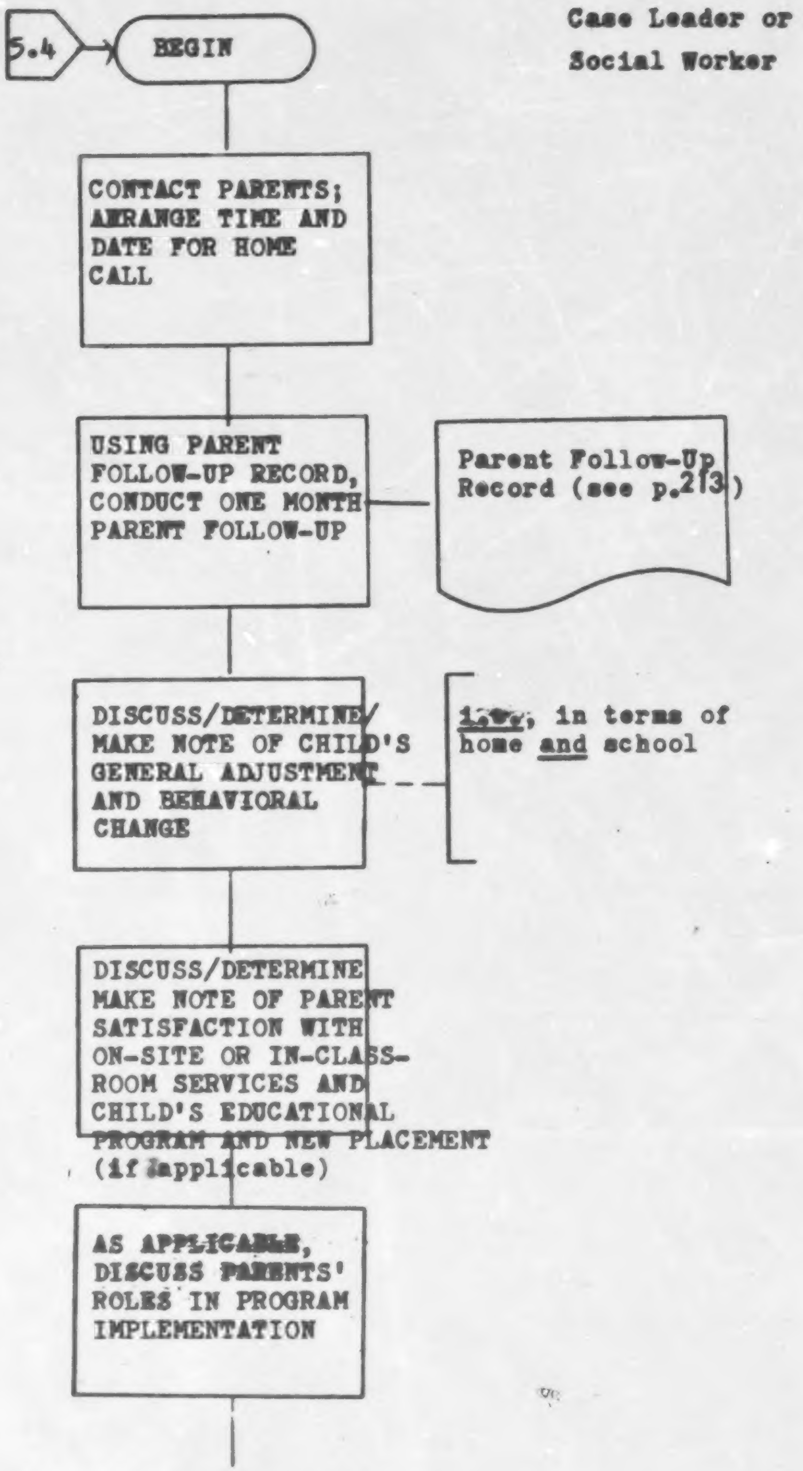
Continued on next page

Chart 5.3 Continued


See
5.9
FORWARD COPY OF TEACHER FOLLOW-UP RECORD TO PROGRAM COORDINATOR FOR INFORMAL EVALUATION
File original in Case Record
UPDATE CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

page three of three

Chart 5.4 CONDUCT ONE MONTH PARENT FOLLOW-UP (Informal Evaluation)


5.4
BEGIN
Case Leader or
Social Worker
CONTACT PARENTS; ARRANGE TIME AND DATE FOR HOME CALL
USING PARENT FOLLOW-UP RECORD, CONDUCT ONE MONTH PARENT FOLLOW-UP
Parent Follow-Up Record (see p.213)
DISCUSS/DETERMINE/ MAKE NOTE OF CHILD'S GENERAL ADJUSTMENT AND BEHAVIORAL CHANGE
i.e., in terms of home and school
DISCUSS/DETERMINE MAKE NOTE OF PARENT SATISFACTION WITH ON-SITE OR IN-CLASSROOM SERVICES AND CHILD'S EDUCATIONAL PROGRAM AND NEW PLACEMENT (if applicable)
AS APPLICABLE, DISCUSS PARENTS' ROLES IN PROGRAM IMPLEMENTATION

Continued on next page

Page one of two

Chart 5.4 Continued

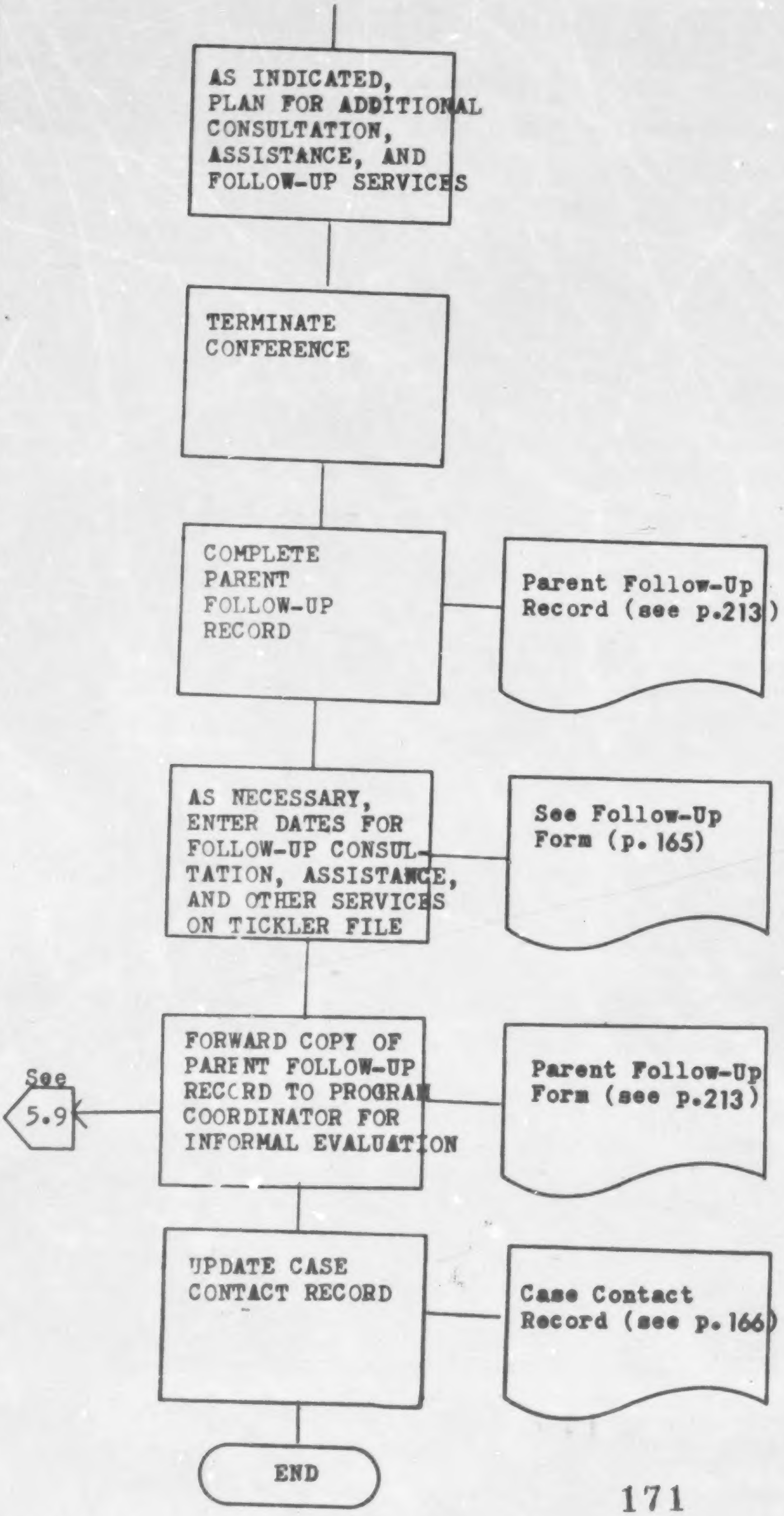

AS INDICATED, PLAN FOR ADDITIONAL CONSULTATION, ASSISTANCE, AND FOLLOW-UP SERVICES
TERMINATE CONFERENCE
COMPLETE PARENT FOLLOW-UP RECORD
Parent Follow-Up Record (see p.213)
AS NECESSARY, ENTER DATES FOR FOLLOW-UP CONSULTATION, ASSISTANCE, AND OTHER SERVICES ON TICKLER FILE
See Follow-Up Form (p. 165)
FORWARD COPY OF PARENT FOLLOW-UP RECORD TO PROGRAM COORDINATOR FOR INFORMAL EVALUATION
Parent Follow-Up Form (see p.213)
See
5.9
UPDATE CASE CONTACT RECORD
Case Contact Record (see p. 166)
END

Chart 5.5 CONDUCT POST PLACEMENT OBSERVATION, TESTING, AND RECORDS COLLECTION

(Formal Evaluation)

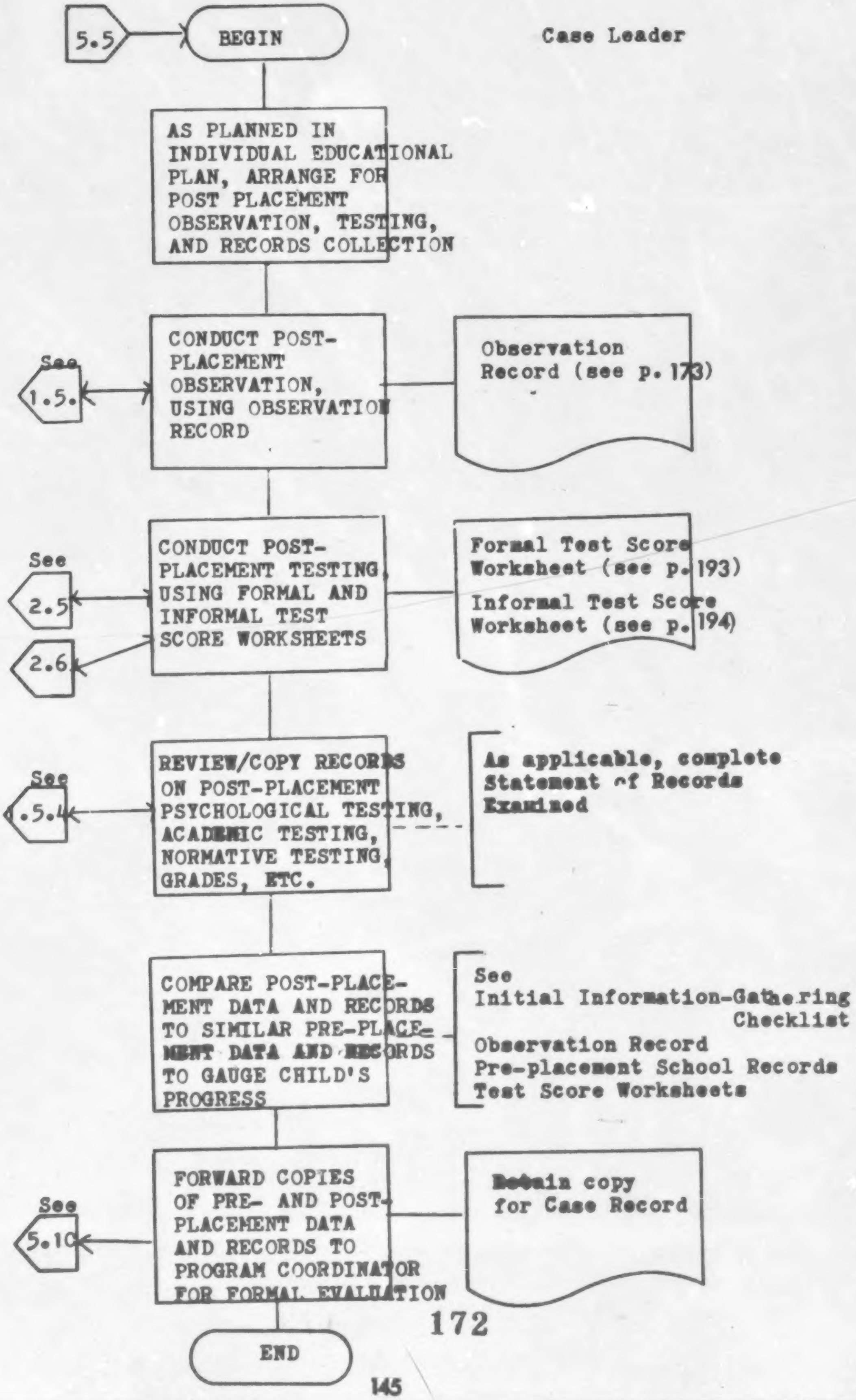
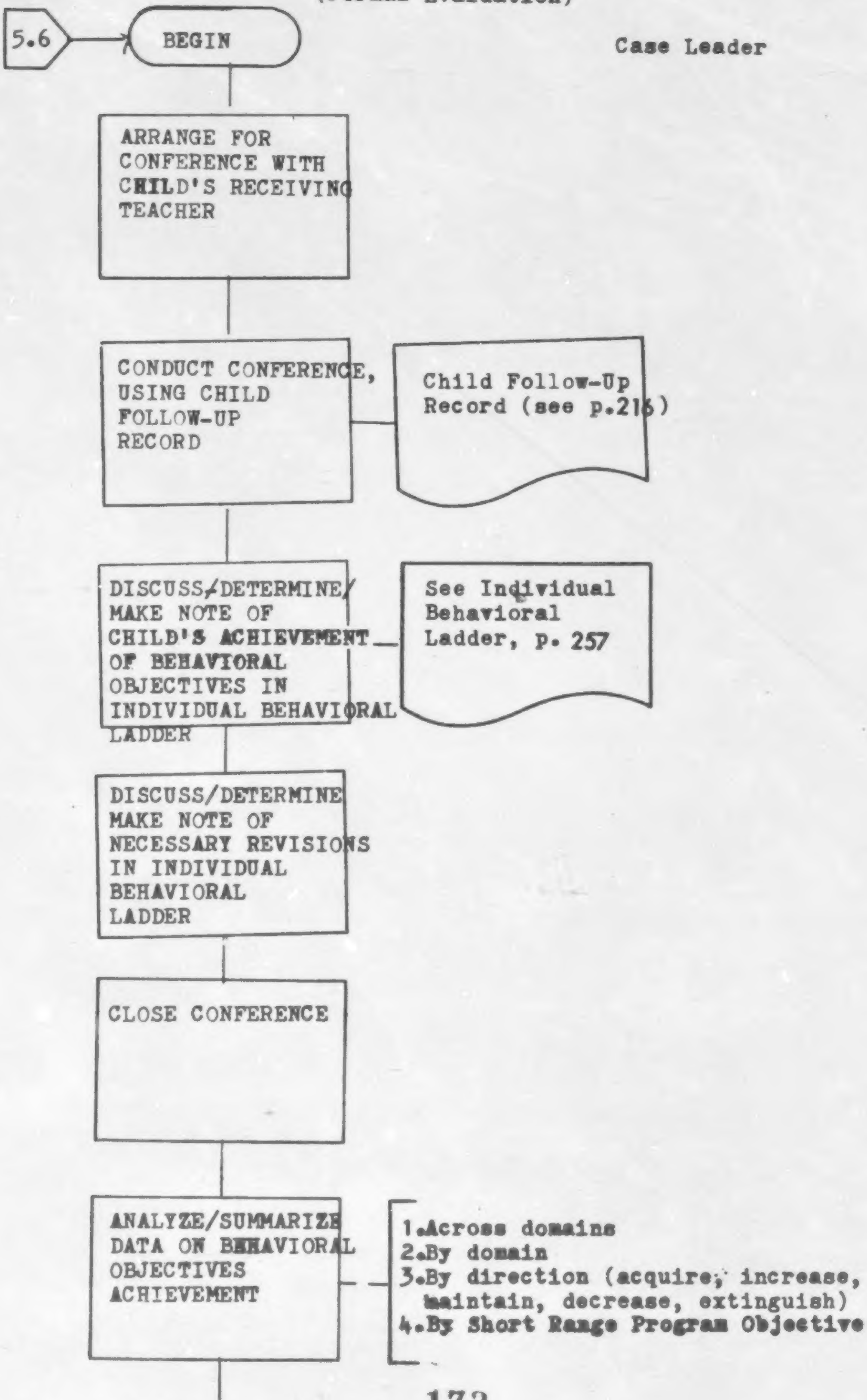

5.5
BEGIN
Case Leader
AS PLANNED IN INDIVIDUAL EDUCATIONAL PLAN, ARRANGE FOR POST PLACEMENT OBSERVATION, TESTING, AND RECORDS COLLECTION
See
1.5.
CONDUCT POST-PLACEMENT OBSERVATION, USING OBSERVATION RECORD
Observation Record (see p. 173)
See
2.5
2.6
CONDUCT POST-PLACEMENT TESTING, USING FORMAL AND INFORMAL TEST SCORE WORKSHEETS
Formal Test Score Worksheet (see p. 193)
Informal Test Score Worksheet (see p. 194)
See
.5.4
REVIEW/COPY RECORDS ON POST-PLACEMENT PSYCHOLOGICAL TESTING, ACADEMIC TESTING, NORMATIVE TESTING, GRADES, ETC.
As applicable, complete Statement of Records Examined
COMPARE POST-PLACEMENT DATA AND RECORDS TO SIMILAR PRE-PLACEMENT DATA AND RECORDS TO GAUGE CHILD'S PROGRESS
See
Initial Information-Gathering Checklist
Observation Record
Pre-placement School Records
Test Score Worksheets
See
5.10
FORWARD COPIES OF PRE- AND POST-PLACEMENT DATA AND RECORDS TO PROGRAM COORDINATOR FOR FORMAL EVALUATION
Retain copy for Case Record
END

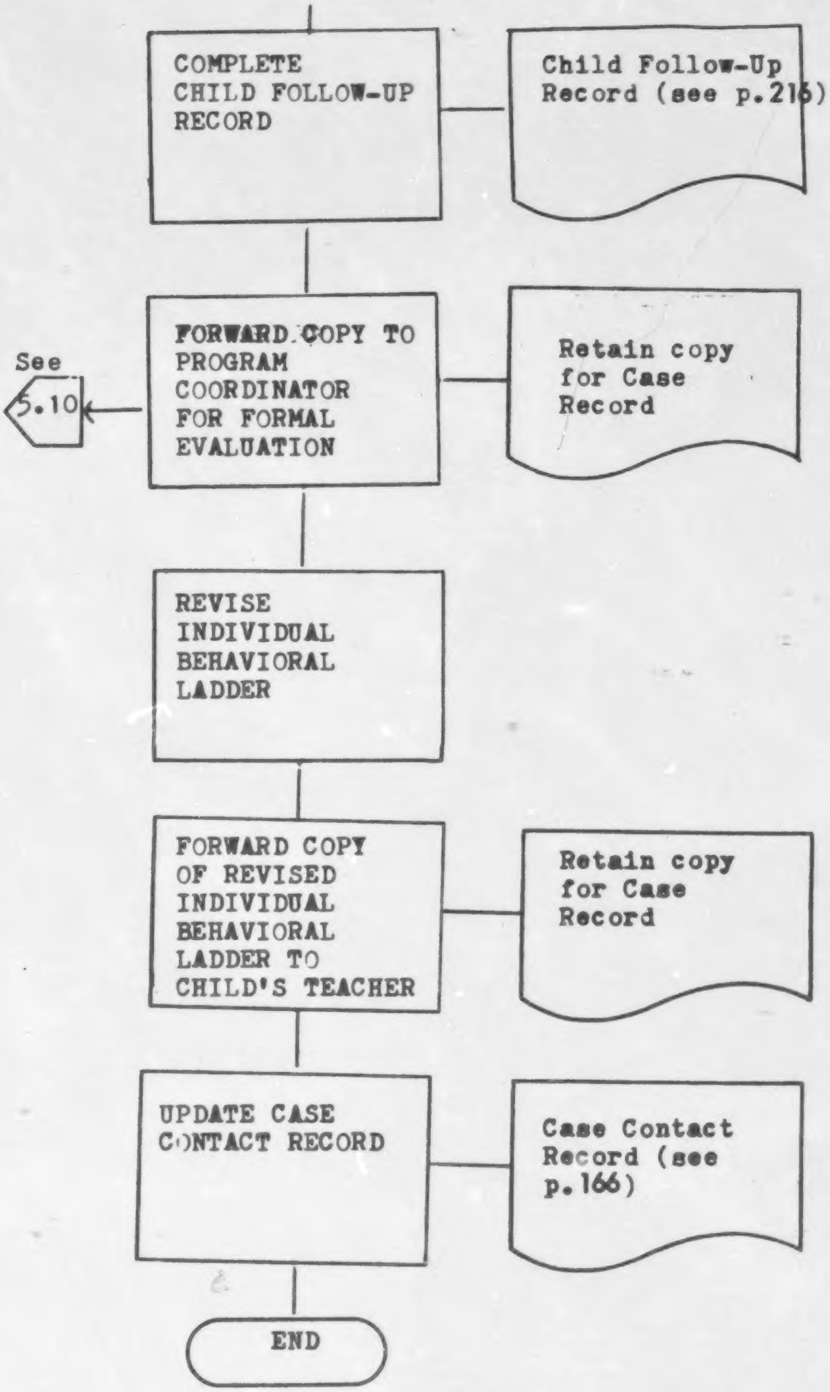
Chart 5.6 CONDUCT 3, 6, 9, AND 12 MONTH CHILD FOLLOW-UP
(Formal Evaluation)


5.6
BEGIN
Case Leader
ARRANGE FOR CONFERENCE WITH CHILD'S RECEIVING TEACHER
CONDUCT CONFERENCE, USING CHILD FOLLOW-UP RECORD
Child Follow-Up Record (see p.216)
DISCUSS/DETERMINE/ MAKE NOTE OF CHILD'S ACHIEVEMENT OF BEHAVIORAL OBJECTIVES IN INDIVIDUAL BEHAVIORAL LADDER
See Individual Behavioral Ladder, p. 257
DISCUSS/DETERMINE MAKE NOTE OF NECESSARY REVISIONS IN INDIVIDUAL BEHAVIORAL LADDER
CLOSE CONFERENCE
ANALYZE/SUMMARIZE DATA ON BEHAVIORAL OBJECTIVES ACHIEVEMENT
1.Across domains
2.By domain
3.By direction (acquire, increase, maintain, decrease, extinguish)
4.By Short Range Program Objective

Continued on next page

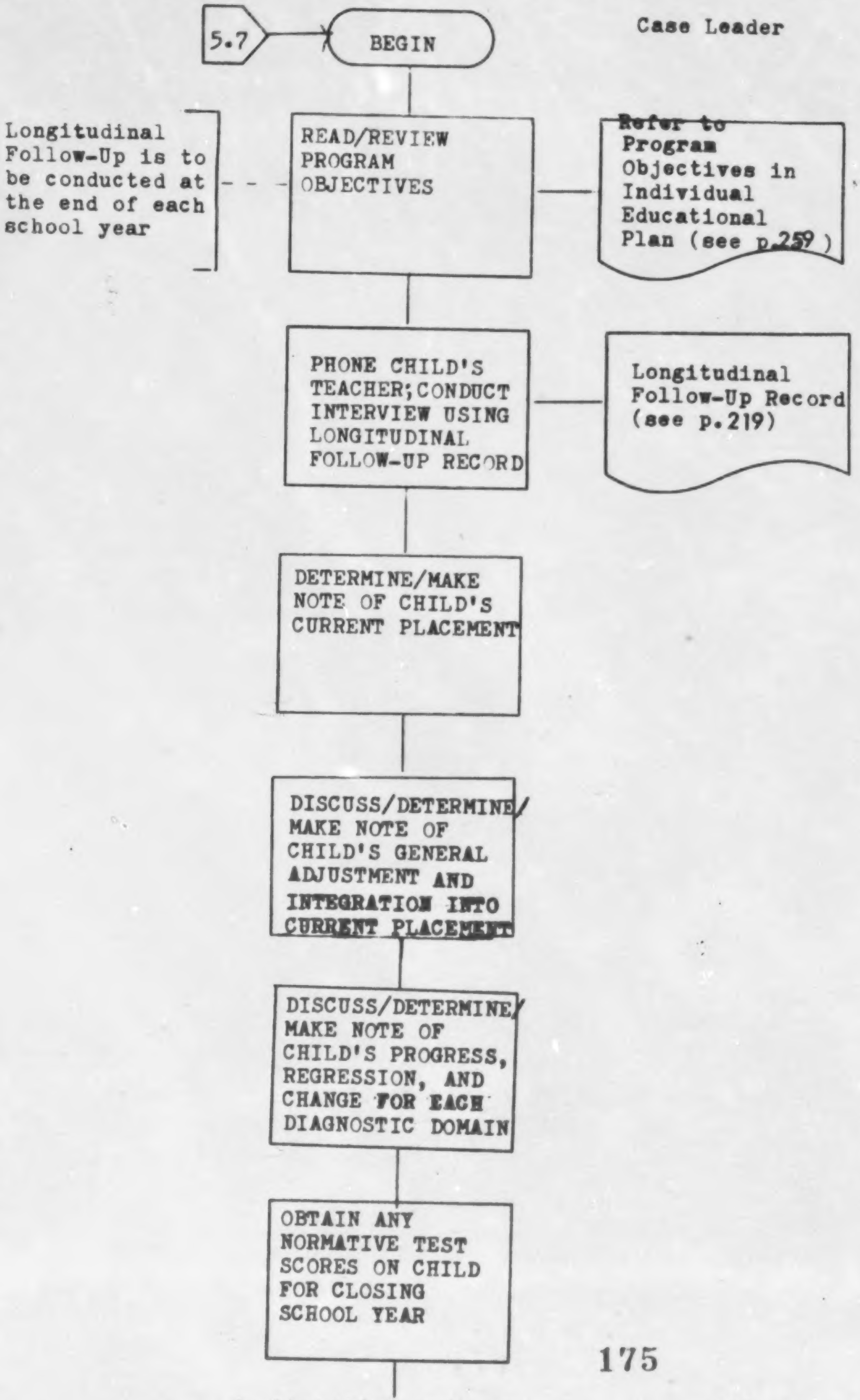
Page one of two

Chart 5.6 Continued


COMPLETE CHILD FOLLOW-UP RECORD
Child Follow-Up Record (see p.216)
FORWARD COPY TO PROGRAM COORDINATOR FOR FORMAL EVALUATION
See 5.10
Retain copy for Case Record
REVISE INDIVIDUAL BEHAVIORAL LADDER
FORWARD COPY OF REVISED INDIVIDUAL BEHAVIORAL LADDER TO CHILD'S TEACHER
Retain copy for Case Record
UPDATE CASE CONTACT RECORD
Case Contact Record (see p.166)
END

Page two of two

Chart 5.7 CONDUCT LONGITUDINAL FOLLOW-UP (**Formal Evaluation**)

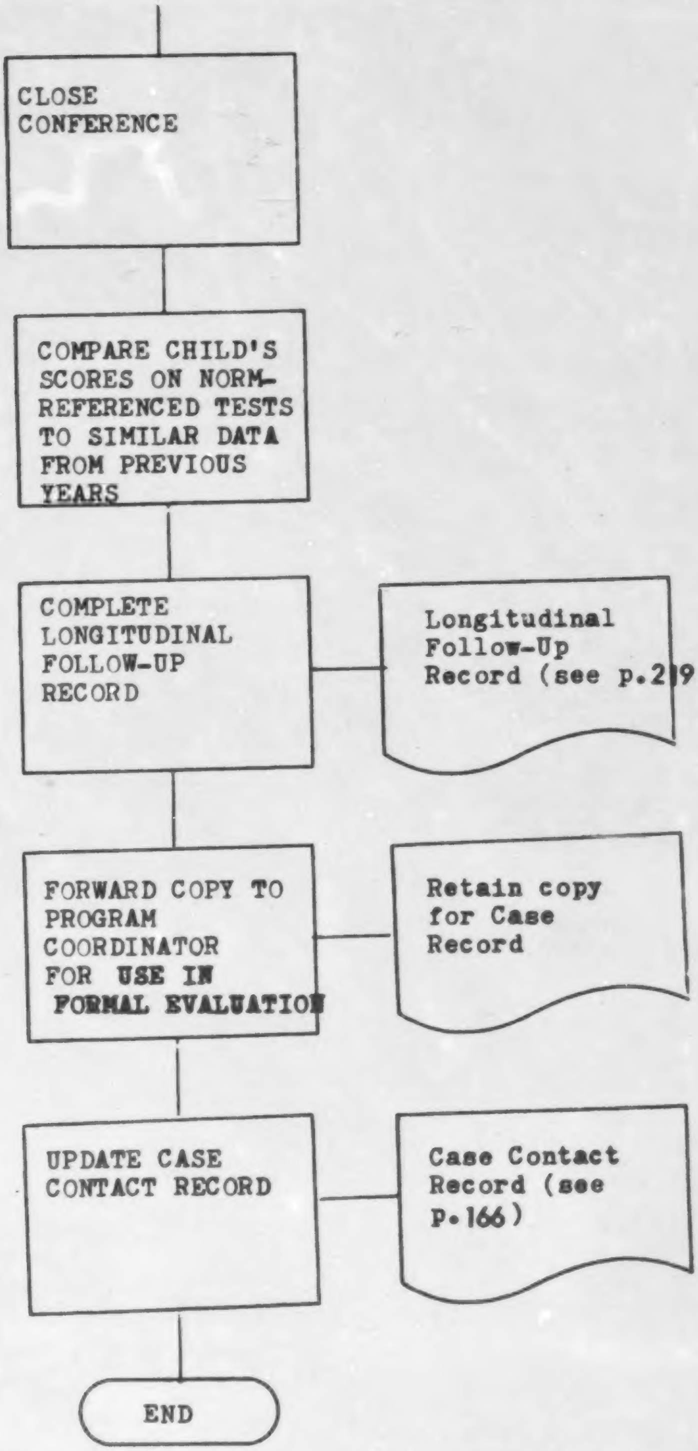


5.7
BEGIN
Case Leader
Longitudinal Follow-Up is to be conducted at the end of each school year
READ/REVIEW PROGRAM OBJECTIVES
~~Refer to~~ Program Objectives in Individual Educational Plan (see p.259)
PHONE CHILD'S TEACHER; CONDUCT INTERVIEW USING LONGITUDINAL FOLLOW-UP RECORD
Longitudinal Follow-Up Record (see p.219)
DETERMINE/MAKE NOTE OF CHILD'S CURRENT PLACEMENT
DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S GENERAL ADJUSTMENT AND INTEGRATION INTO CURRENT PLACEMENT
DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S PROGRESS, REGRESSION, AND CHANGE FOR EACH DIAGNOSTIC DOMAIN
OBTAIN ANY NORMATIVE TEST SCORES ON CHILD FOR CLOSING SCHOOL YEAR

Continued on next page

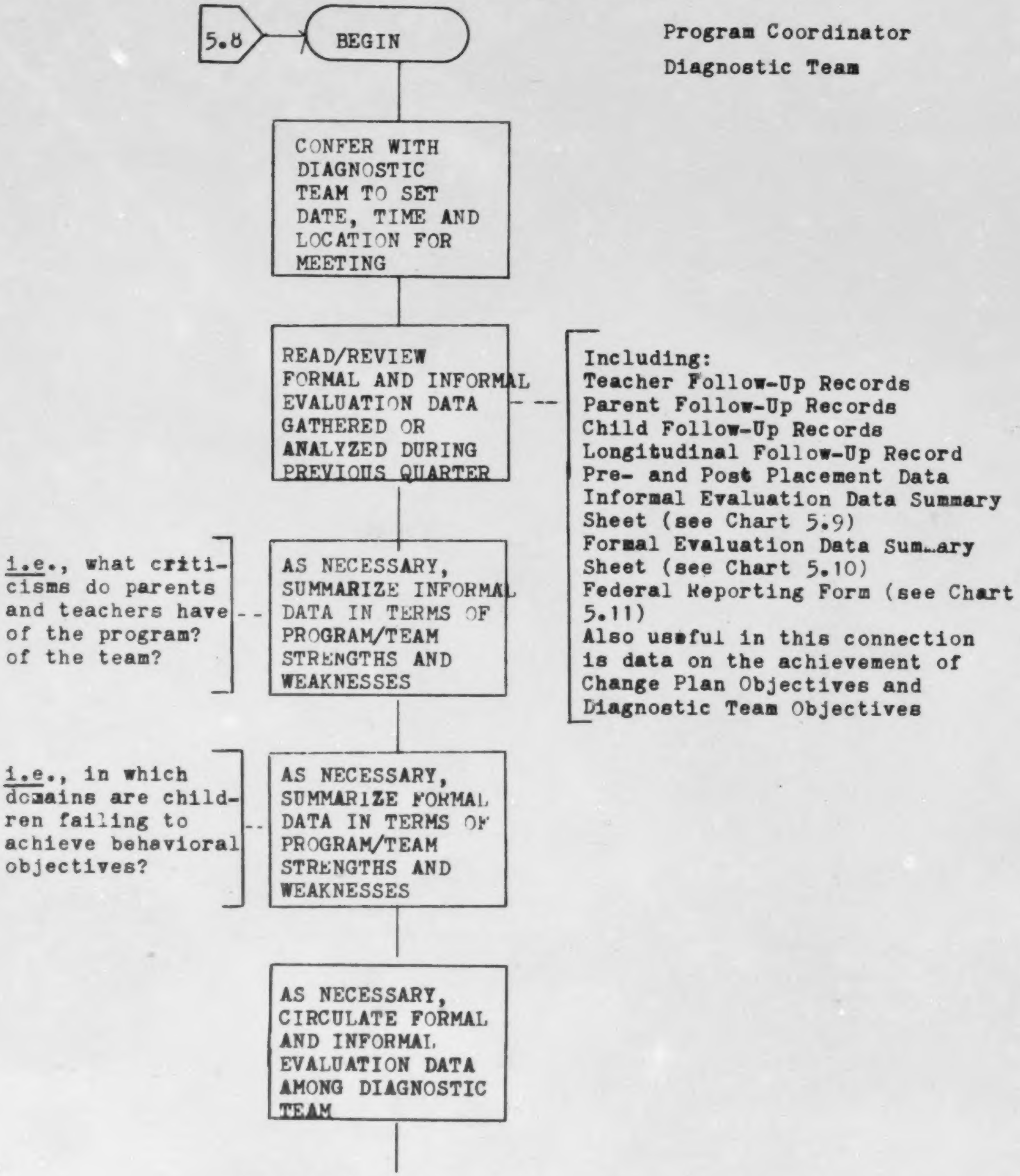
Page one of two

Chart 5.7 Continued


CLOSE CONFERENCE
COMPARE CHILD'S SCORES ON NORM-REFERENCED TESTS TO SIMILAR DATA FROM PREVIOUS YEARS
COMPLETE LONGITUDINAL FOLLOW-UP RECORD
Longitudinal Follow-Up Record (see p.219)
FORWARD COPY TO PROGRAM COORDINATOR FOR USE IN FORMAL EVALUATION
Retain copy for Case Record
UPDATE CASE CONTACT RECORD
Case Contact Record (see p.166)
END

Page two of two

Chart 5.8 PLAN/CONDUCT/PARTICIPATE IN QUARTERLY STAFF MEETING


5.8
BEGIN
Program Coordinator
Diagnostic Team
CONFER WITH DIAGNOSTIC TEAM TO SET DATE, TIME AND LOCATION FOR MEETING
READ/REVIEW FORMAL AND INFORMAL EVALUATION DATA GATHERED OR ANALYZED DURING PREVIOUS QUARTER
AS NECESSARY, SUMMARIZE INFORMAL DATA IN TERMS OF PROGRAM/TEAM STRENGTHS AND WEAKNESSES
AS NECESSARY, SUMMARIZE FORMAL DATA IN TERMS OF PROGRAM/TEAM STRENGTHS AND WEAKNESSES
AS NECESSARY, CIRCULATE FORMAL AND INFORMAL EVALUATION DATA AMONG DIAGNOSTIC TEAM

Including:
Teacher Follow-Up Records
Parent Follow-Up Records
Child Follow-Up Records
Longitudinal Follow-Up Record
Pre- and Post Placement Data
Informal Evaluation Data Summary Sheet (see Chart 5.9)
Formal Evaluation Data Summary Sheet (see Chart 5.10)
Federal Reporting Form (see Chart 5.11)
Also useful in this connection is data on the achievement of Change Plan Objectives and Diagnostic Team Objectives

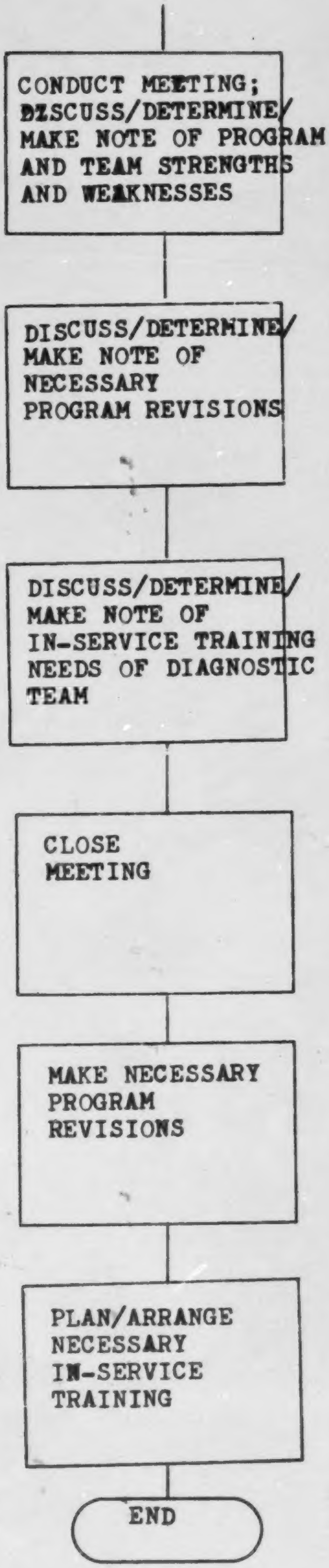
i.e., what criticisms do parents and teachers have of the program? of the team?

i.e., in which domains are children failing to achieve behavioral objectives?

Continued on next page

Page one of two

Chart 5.8 Continued


CONDUCT MEETING; DISCUSS/DETERMINE/ MAKE NOTE OF PROGRAM AND TEAM STRENGTHS AND WEAKNESSES
DISCUSS/DETERMINE/ MAKE NOTE OF NECESSARY PROGRAM REVISIONS
DISCUSS/DETERMINE/ MAKE NOTE OF IN-SERVICE TRAINING NEEDS OF DIAGNOSTIC TEAM
CLOSE MEETING
MAKE NECESSARY PROGRAM REVISIONS
PLAN/ARRANGE NECESSARY IN-SERVICE TRAINING
END

Page two of two

Chart 5.9 CONDUCT ANNUAL ANALYSIS OF INFORMAL EVALUATION DATA

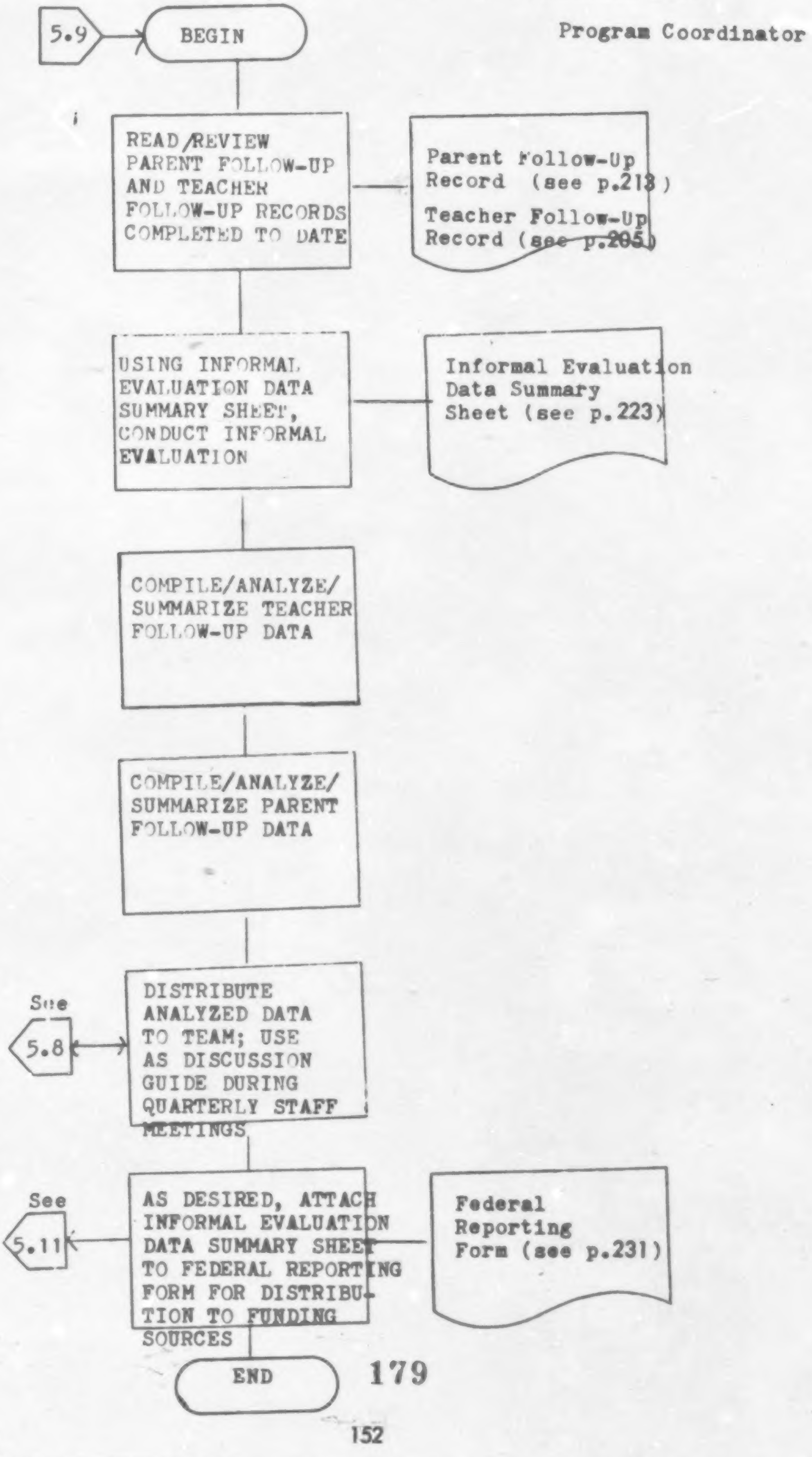
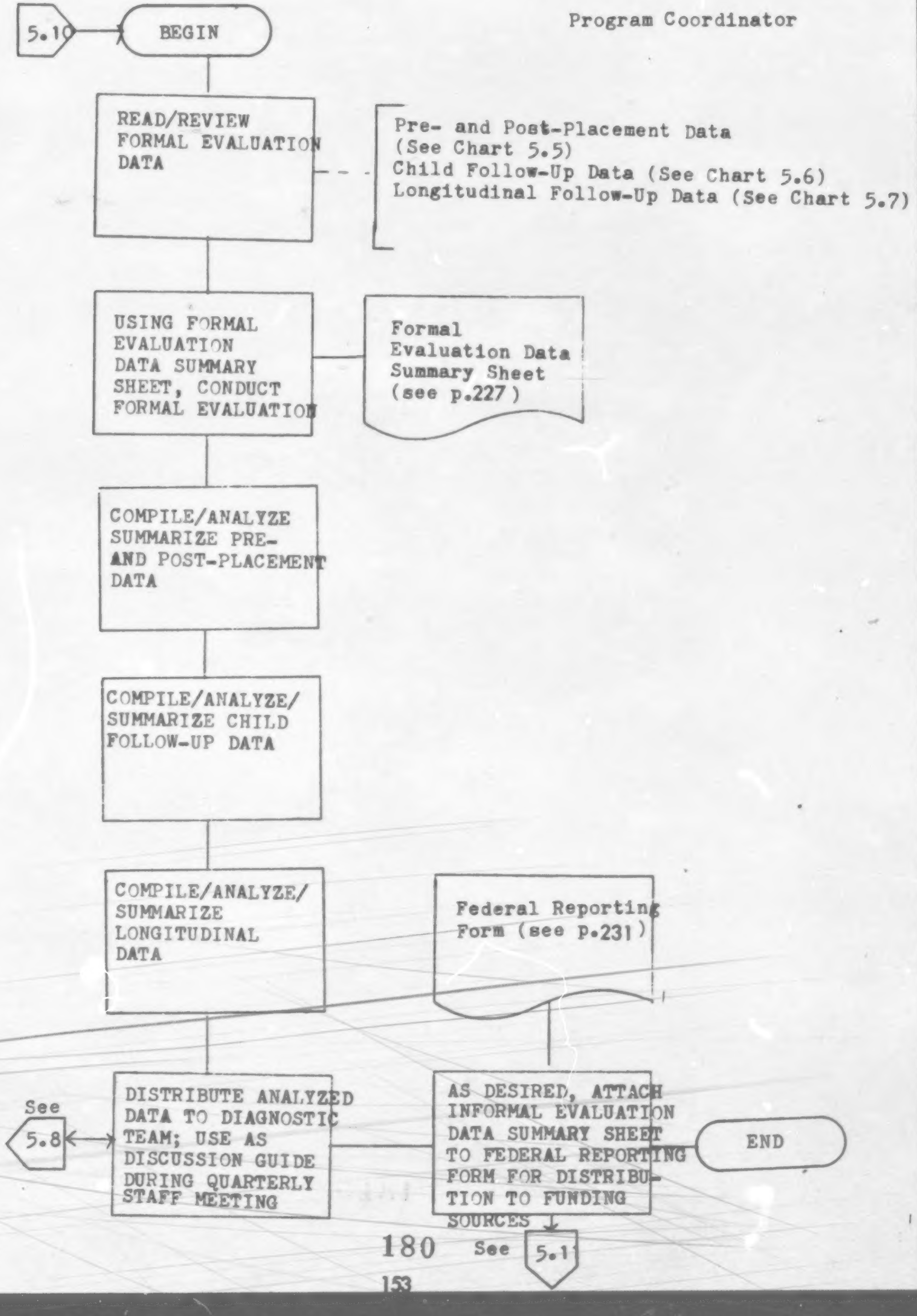
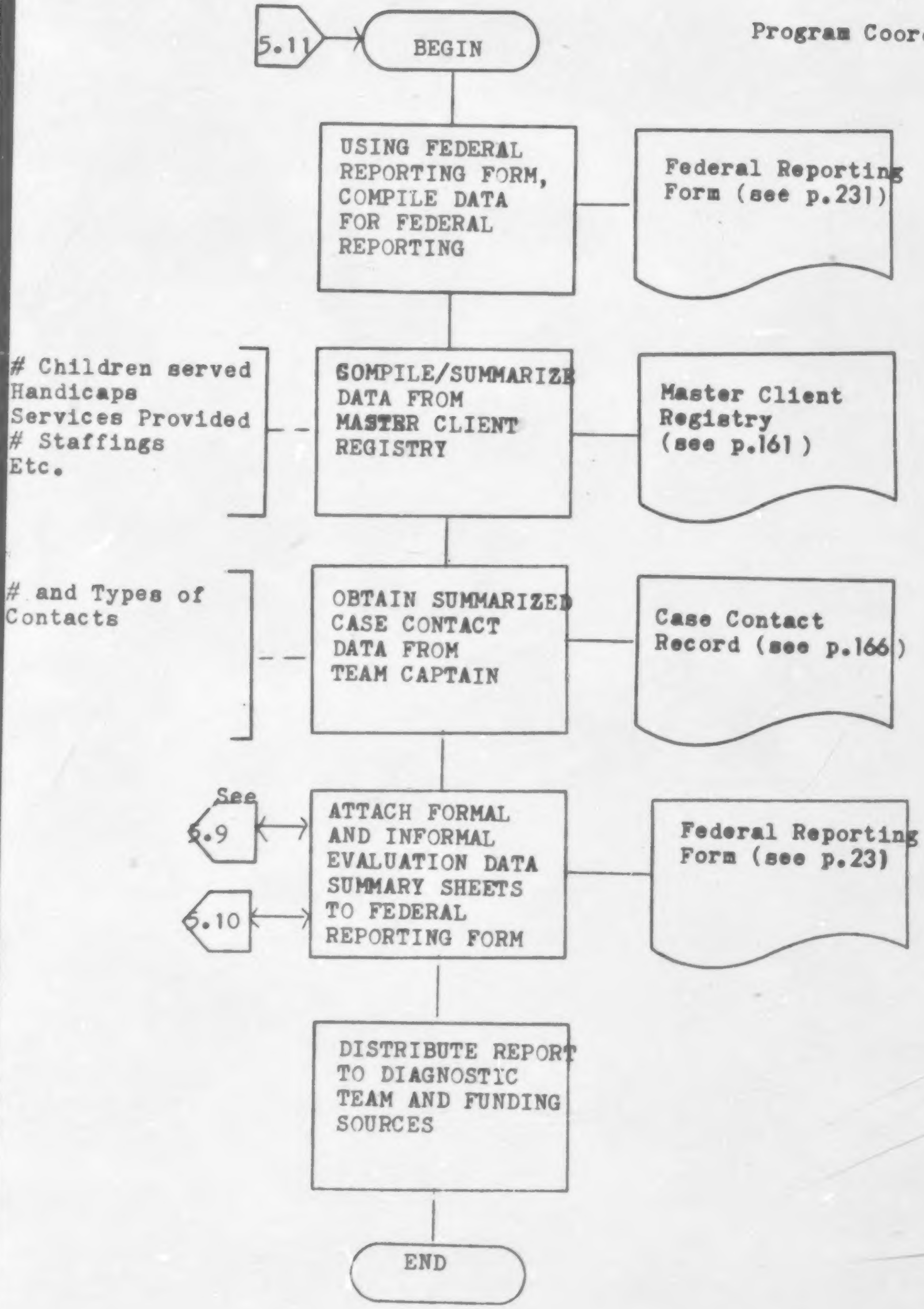

5.9
BEGIN
Program Coordinator
READ/REVIEW PARENT FOLLOW-UP AND TEACHER FOLLOW-UP RECORDS COMPLETED TO DATE
Parent Follow-Up Record (see p.213)
Teacher Follow-Up Record (see p.205)
USING INFORMAL EVALUATION DATA SUMMARY SHEET, CONDUCT INFORMAL EVALUATION
Informal Evaluation Data Summary Sheet (see p.223)
COMPILE/ANALYZE/SUMMARIZE TEACHER FOLLOW-UP DATA
COMPILE/ANALYZE/SUMMARIZE PARENT FOLLOW-UP DATA
See
5.8
DISTRIBUTE ANALYZED DATA TO TEAM; USE AS DISCUSSION GUIDE DURING QUARTERLY STAFF MEETINGS
See
5.11
AS DESIRED, ATTACH INFORMAL EVALUATION DATA SUMMARY SHEET TO FEDERAL REPORTING FORM FOR DISTRIBUTION TO FUNDING SOURCES
Federal Reporting Form (see p.231)
END

Chart 5.10 CONDUCT ANNUAL ANALYSIS OF FORMAL EVALUATION DATA


Program Coordinator
5.10
BEGIN
READ/REVIEW FORMAL EVALUATION DATA
Pre- and Post-Placement Data (See Chart 5.5)
Child Follow-Up Data (See Chart 5.6)
Longitudinal Follow-Up Data (See Chart 5.7)
USING FORMAL EVALUATION DATA SUMMARY SHEET, CONDUCT FORMAL EVALUATION
Formal Evaluation Data Summary Sheet (see p.227)
COMPILE/ANALYZE SUMMARIZE PRE- AND POST-PLACEMENT DATA
COMPILE/ANALYZE/SUMMARIZE CHILD FOLLOW-UP DATA
COMPILE/ANALYZE/SUMMARIZE LONGITUDINAL DATA
Federal Reporting Form (see p.231)
See
5.8
DISTRIBUTE ANALYZED DATA TO DIAGNOSTIC TEAM; USE AS DISCUSSION GUIDE DURING QUARTERLY STAFF MEETING
AS DESIRED, ATTACH INFORMAL EVALUATION DATA SUMMARY SHEET TO FEDERAL REPORTING FORM FOR DISTRIBUTION TO FUNDING SOURCES
END
See
5.11

Program Coordinator


5.11
BEGIN
USING FEDERAL REPORTING FORM, COMPILE DATA FOR FEDERAL REPORTING
Federal Reporting Form (see p.231)
# Children served
Handicaps
Services Provided
# Staffings
Etc.
COMPILE/SUMMARIZE DATA FROM MASTER CLIENT REGISTRY
Master Client Registry (see p.161)
# and Types of Contacts
OBTAIN SUMMARIZED CASE CONTACT DATA FROM TEAM CAPTAIN
Case Contact Record (see p.166)
See
5.9
5.10
ATTACH FORMAL AND INFORMAL EVALUATION DATA SUMMARY SHEETS TO FEDERAL REPORTING FORM
Federal Reporting Form (see p.231)
DISTRIBUTE REPORT TO DIAGNOSTIC TEAM AND FUNDING SOURCES
END

Section 3.

EXHIBITS

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Exhibit	Title	Page
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X.	Formal Evaluation Data Summary	227
Y.	Federal Reporting Form	231

EXHIBIT A

REFFERAL FOR SERVICES

NAME:__________________ SEX:__________ BIRTHDATE:__________

PHONE:__________ PARENTS' NAME:__________________________

HOME ADDRESS:__________________ CITY:____________ ZIP CODE:______

RESIDENT DISTRICT:____________ COUNTY:__________ CITY:______________

SCHOOL ATTENDING:____________ COUNTY:__________ GRADE:__________

TEACHER:____________________

Child's major problems (check all that apply):

1.______No handicaps

2.______Retarded

3.______Orthopedic

4.______Speech Impaired

5.______Hearing Impaired

6.______Deaf

7.______Visually Impaired

8.______Blind

9.______Emotionally disturbed

10.______Learning Disabilities

11.______Other (Specify)

____

____

____

____

Services Requested (Check all that apply)

1.______Diagnostic Classroom Placement

2.______Consultation (Check all that apply)

  a.______Psychologist

  b.______Social Worker

  c.______Consulting Diagnostic Teacher

  d.______Deaf Educator

  e.______Vision Educator

  f.______Other (Please specify)______

3.______Contractual Medical (Please specify) ____________________________

4.______Other (Please specify)______________________________

Please list the questions you want answered about the child:

Pertinent Comments:

Family Physician:____________________ Address:____________________

Specialists:____________________ Address:____________________

____
Signature and Title of Person Referring the Child

____
Date

____
Telephone

____
Approved by: Regional Program Director

Please contact:

Telephone:

PARENTAL CONSENT FORM

DATE:________________________

To Whom It May Concern:

We hereby give permission and consent for____

____

to release the following confidential information regarding our child, (child's name)____________

____

______ Achievement Test Scores

______ Psychological Report

______ Social Development Reports

______ Medical Reports

______ Speech and Language Report

______ Audiological Report

______ Annual School Progress Report

______ Other__________________

We have read this consent form and understand its implications, and therefore, we affix our signatures.

Father: __________________________

Mother: __________________________

Please address all correspondence to:

EXHIBIT B

MASTER CLIENT REGISTRY

1. Client Name:	2. ID #	3. Zip Code
4. Handicap Code:	5. Age Code:	6. Severity Code:
7. Date of Referral:	8. Case Leader:	

Services Requusted (check all that apply)	Services Provided (Check all that apply)	Dates
1. Diagnostic Classroom Placement ______	______	______
2. Consultation a. Psychologist ______	______	______
b. Social Worker ______	______	______
c. Consulting Diagnostic Teacher ______	______	______
d. Deaf Educator ______	______	______
e. Vision Educator ______	______	______
f. Other (Specify) ______	______	______
3. Contractual Medical (Specify) ______	______	______
4. Other (Specify) ______	______	______

MASTER CLIENT REGISTRY CODES

Federal Handicap Code

A. No Handicap
B. Retarded
C. Hard of Hearing
D. Deaf
E. Speech Impaired
F. Visually Handicapped
G. Seriously Emotionally Disturbed
H. Crippled
I. Other Health Impairments
J. Hearing Disabilities
K. Multiple (Specify J - K above)

Severity Code

A. No Handicap
B. Mild
C. Moderate
D. Severe

Age Code

A. Under 5
B. 5 - 15
C. Over 15

REGIONAL RESOURCE CENTER
STATE OF ILLINOIS
(PL 91-230, TITLE VI, SEC. 621)
3202 N. WISCONSIN AVENUE
PEORIA, ILLINOIS 61603

HAROLD BERJOHN
DIRECTOR
309-672-6717

ADMINISTRATIVE AGENT
PEORIA PUBLIC SCHOOLS
DISTRICT 150

DEA BOKER
ASSISTANT DIRECTOR
309-672-6725

RE: Use of Direct Service Funds

Dear

The Regional Resource Center has available direct flow-through money from the federal government which can be used to assist handicapped children through diagnosis. This money may purchase medical diagnosis, speech and language diagnosis, hearing evaluations, or any other type of diagnostic work which is deemed necessary for a child with unexplained handicapping conditions.

In order to request the use of this money for a specific child, we need a letter from the Special Education Director or Diagnostic Classroom Program Coordinator which includes the following information:

1. Name and birthdate of Child
2. Address including Zip Code
3. Specific nature of problem
4. Type of evaluation desired
5. Approximate cost
6. Specific doctor or clinic to be used
7. A statement verifying that the local special education district has exhausted all possibilities for assistance to this child

When this information is received, we will consider the request and, in almost every case, grant it. We will write a letter giving our approval and you may then make direct appointment necessary for completion of the diagnostics approved. If there is travel expense for the parents to take the child to the diagnostician, this will also be paid by the RRC when the parents submit their mileage to us. You may request the diagnostician to send their bill directly to me at the RRC, 3202 N. Wisconsin, Peoria, Illinois 61603

After the diagnosis is completed, we request that you write us an additional letter commenting on the value of the service rendered. This is necessary for our files, and we would appreciate your help with it.

We hope that you will avail yourself of this fund in cases of need. If you have any questions concerning a child or the use of the funds, please feel free to call. My number is (309) 672-6725. We hope we will be able to serve the handicapped in your area. This service is available through January 31, 1977.

Sincerely,

Dea Boker
Assistant Director
Regional Resource Center

DB/jdb

EXHIBIT D

FOLLOW - UP FORM

DATE INITIATED____________________

TEAM MEMBER RESPONSIBLE______________________________

CASE NAME:____

________________ 1st Control Date	________________ 2nd Control Date	________________ 3rd Control Date

Notes:

Action Completed ____ (Return toControl Clerk) ______ (Remove Control for other reasons)

EXHIBIT E.

CASE CONTACT RECORD

Name of Child: ______________________ **Birthdate:** ______________________ ID ______________________

DATE OF CONTACT:	TYPE OF CONTACT:					CONTACT PERSONS:						PURPOSE OF CONTACT:							COMMENTS:
	Phone	Conference	Staffing	Home Call	Other	Other Resource Person (Specify Type)	Support Staff (Specify Type)	Medical Consultant (Specify)	Administrator	Sending/Receiving Teacher	Parents	Provide Technical Assistance	Gather Information	Provide Information	Provide Training	Give Demonstration	Receive Technical Assistance	Follow-Up	

EXHIBIT F

INITIAL INFORMATION GATHERING CHECKLIST

INSTRUCTIONS: This form is to be completed by the Case Leader within two weeks of receipt of the Referral Form. It is to be used during the initial conference with the child's sending teacher and/or other representatives of the referring agency or school and may be employed as a) a record of previous diagnostic work, b) the basis for the development of Diagnostic Team objectives, c) the basis for the development of initial program prescriptions, d) a baseline against which post -placement performance and behavioral data may be compared, e) and a tool for the tailoring of program prescriptions to receiving school constraints.

Name of Child: Date:

Referring Agency: I.D.#:

Child's Current Placement Program:

Case Leader: Title:

Conference Participants:

A. General Information:

1. What, in the opinion of the sending school staff, are the child's strengths?

2. What are the child's weaknesses?

3. How does the child relate to:

a. other children:

b. adults:

c. his or her assigned tasks?

4. What general observations have been made in each of the following areas?

   a. Motor Skills?

   b. Sensory - Perceptual Skills?

   c. Speech and Language?

   d. Academics (school - age only) ?

   e. Social - Emotional:

   f. Self - help?

C. Characteristic Negative Behaviors

1. List below the child's characteristic negative behaviors and their frequencies:

2. What factors precipitate negative behaviors in the child?

D. Prior Programming and Placements

1. What rewards and punishments have been used with the child? Which have worked? Which have not worked?

2. What instructional methods, materials, and equipment and teaching strategies have been tried with the child? What have been the outcomes?

3. What have been the child's previous placements? Have any worked out better than others? If yes, which ones and why?

4. What human and material resources will the sending school be able to allocate to implementation of the child's educational program?

5. What are the constraints of the sending school staff (especially the sending teacher) which may affect the nature of the child's program? (e.g. time, equipment, and materials limitations, etc.)?

EXHIBIT G

RECORD OF INSPECTION OF STUDENT RECORDS

Records Examined ____
(Name of student)

Date: ____________________

Records Examined by: ____________________________________

Purpose: ____

____

____

____

Date: ____________________

Records Examined by: ____________________________________

Purpose: ____

____

____

Date: ____________________

Records Examined by: ____________________________________

Purpose: ____

____

____

____

Any request to inspect a student's record must state specifically the legitimate educational or other interest of such persons and their right to such information.

EXHIBIT H

CHILD OBSERVATION RECORD

________ Initial On-Site Observation
________ Follow-Up Observation

Instructions: This form is for use by the Consulting Diagnostic Teacher and the Diagnostic Classroom Teacher in a) Initial on-site observation of the child and b) On-site follow-up observation of the child. As such, it serves as a record of the child's pre-placement and post-placement behaviors in a normal classroom setting, and can be used to track the child's behavioral progress, regression, and change. The information from the Child Observation Record is also useful in the initial selection of all program prescriptions, including instructional materials, teaching strategies, learning environment strategies, and motivational strategies.

A. General Information

Date:________________________ Name of Observer:________________________

Name of Child:____

Child's Current Placement or Program:________________________________

Observation Setting:

a) Name of facility of classroom:________________________
b) Physical setting:________________________
c) Time of observation:____________
d) Number and roles of adults present during observation:________________
____
____
e) Number of child's peers present:________________________
f) Was child aware of observer's presence?________ Yes ________ No
g) Is this setting part of the child's day-to-day environment?________ Yes ________ No

B. Summary and Conclusions

1. Observer Summary. (Include a statement of any patterns observed in columns I-IV of the Child Observation Record. Be certain to note the rewards and punishments which were particularly effective or ineffective.)

2. If applicable, how does this Child Observation Record compare to previous Observation Records?

3. Observer Conclusions and Recommendations:

C. Child Observation Record

Use the following format to list all positive and negative behaviors observed in the child during the period of observation. Even if the child does nothing particularly noteworthy, list what he does do. For example, the child may simply sit quietly for ten minutes--a seemingly unimportant behavior. However, in the event that at some future date the child becomes disruptive, this baseline data will provide a most useful standard of comparison.

For each behavior listed in column I, complete the following:

Column II: Circumstances Initiating the Behavior. This may be any stimulus--physical, verbal, or non-verbal--which appeared to elicit the behavior, such as, "Teacher aide frowned at child." "Teacher instructed the group to _______." "Child in next desk threw spitball." "School bell rang." If there were no apparent initiating circumstances, write "none."

Column III: Conditions. This section should include remarks on any noteworthy task-related or environmental factors operant at the time of the observed behavior, such as the child's assignment, materials, equipment, furniture, degree of independence or group involvement, positioning in the classroom, etc.

Column IV: Teacher/Peer Response. In this column enter the reaction to the child's behavior displayed by the teacher and/or students.

Column V: Comments. Note any additional remarks on the child's behavior, its causes, and its outcomes.

CHILD OBSERVATION RECORD

Date: ____________ Name of Observer: ____________________

Name of Child: ____________

I. CHILD BEHAVIOR OR PERFORMANCE	II. INITIATING CIRCUMSTANCES	III. CONDITIONS	IV. TEACHER/PEER RESPONSE	V. COMMENTS

EXHIBIT I

CHILD INTERVIEW RECORD

INSTRUCTIONS: The Child Interview Record is to be completed by the Case Leader or Social Worker during the initial on - site visit to the child's sending school. If possible, the interview should be conducted privately within two weeks of receipt of the Referral Form. The information from the Child Interview is to be used in the development of Diagnostic Team Objectives, Program Objectives, initial program prescriptions, and placement recommendations.

A. GENERAL INFORMATION

Name of Child Date:

I.D.#:

Child's Current Placement or Program:

Interviewer:

Interview setting. (Facility and persons present).

B. INTERVIEW AREAS

1. General

   a. Do you have brothers and sisters ?

   b. How old are you?

   c. What do you like to do?

   d. What are your favorite play activities?

   e. What are your favorite toys?

   f. What is your favorite music?

   g. What are your favorite sports?

   h. What are your favorite T.V. Shows?

   i. What do you want to be?

2. Family relationships

   a. What do you like best about your family (siblings) ?

   b. What do you like least?

3. Peer Relationships

   a. What are your friends like?

   b. What do you like about your friends?

   c. Why do you think they like you?

   d. Do you ever fight or argue with them?

   e. Why?

4. Schooling

a. What do you like most about school?

b. What do you like least?

c. Who has been your favorite teacher? Why?

d. Have you ever had a teacher you didn't like? Why?

e. What are your favorite:

(1) books?

(2) playground or classroom equipment?

(3) games?

f. What is your favorite class period or activity?

g. If you could learn anything you wanted to in school, what would you want to learn?

5. Other

EXHIBIT J

HOME CALL CHECKLIST

INSTRUCTIONS: The Home call Checklist must be completed by the Team Social Worker within two weeks of receipts of the Referral Form. The information gathered during the home visit is to be used in the development of the Diagnostic Team Objectives, the Diagnostic Summary, and the Long and Short Range Program Objectives.

A. GENERAL INFORMATION

Name of Child:

Date:

Interviewer:

I.D.#:

Name of Parent or Guardian:

Address:

Phone:

B. MEMBERS OF HOUSEHOLD

1. Sex and age:
   - a. Siblings:
   - b. Relatives (specify relationship):
   - c. Other household members:
2. Parent Occupation:
   - a. Mother (specify if other than mother):
   - b. Father (specify if other than father):
3. Parental Employment History:
4. Parental Marital History:

5. Child's Relationship with Parents:

6. Child's Relationship with Siblings:

7. Family Attitude Toward Child and Child's Handicap:

8. Child's Peer Relationships:

9. Child's Prior Programming and Placements and Their Outcomes:

10. Child's Special Interests:

11. Child's Favorite Play Activities, Toys, Games, Books, etc.:

12. Child's In-Home Positive and Negative Behaviors:

13. Rewards and Punishments Used by Parents and Their Effectiveness:

14. Parental Concerns (i.e., questions parents would like to have answered re: child):

15. Parental Expectations for Child (i.e., long and short range; at home and in school):

16. Parents' Willingness to Assist in Program Implementation:

17. Suggested Resource Persons (Names and Telephone Numbers):

1. Family Doctor:
2. Hospital Personnel:
3. Mental Health Professionals:
4. Public Health Professionals:
5. Public Welfare Agency Staff:
6. Other:

18. Other Comments

EXHIBIT K.

Code: ___

This information is confidential
and will be used only for the
benefit of your child.

Please complete all portions
of this form that apply to your
child. If some sections do
not apply please disregard.

HEALTH HISTORY

A. Identifying Information:

Name: ___ Birthdate: ___

Address: ___ Telephone: ___

City: ___ County: ___

School: ___ Teacher: ___

Child lives with: ___ Grade: ___

Address: ___

Phone: ___

Parents:

Mother: ___ Address: ___

Birthdate: ___ Occupation: ___

Father: ___ Address: ___

Birthdate: ___ Occupation: ___

Other Children: Name:	Birthdate:	Grade

Service Agency Contacts (Please List): ___

1. Has child had a recent physical examination? ___ Date: ___
2. Name and address of family physician and/or pediatrician. ___

3. Is there any history of a handicapping condition in the child's family? (eye, emotional, speech, hearing, or physical problem (s), etc.) ____________________

____

Describe: ____________________

____

4. Describe your major concern (s) about your child. ____________________

____

____

5. What questions would you like to have answered? ____________________

____

____

6. Has the child been seen by a Neurologist? ________ Psychologist? ______ Had an EEG? Has his Speech or Hearing been tested? ______ Has child had training in a speech, hearing, language, or developmental center? ________ If "YES" to any of the above, please explain and give dates. ____________________

____

____

7. Is this child presently on any type of medication? ________ For what? ________

____

8. Has your child been screened for vision, hearing and/or speech? If so, what were the findings? ____________________

____

B. Prenatal and Birth History:

1. Was pregancy normal? ________ If not, explain ____________

____

2. What illnesses did mother have during pregancy? (measles, mumps, flue, etc.)

____

3. Any falls or accidents during pregnancy? ____________________

____

4. Was pregancy full term? ________ If not, explain ____________

5. Was delivery normal? ____________________

6. Length of labor? ____________________

7. What drugs were used during pregancy and/or at delivery? ____________

____

8. Instruments used? ________

9. What was the child's condition at birth? ________
color good? ________ breathe easily? ________ birth weight? ________

10. Name and address of attending physician ________

11. Was there Rh incompatibility? ________

12. Was infant placed in an incubator following birth? ________ Describe ________
____

13. Was any special medical attention or hospitalization required for this child during the first three months? ________

14. Mother's age at this pregancy? ________ What numbered pregancy? ________

15. How did this delivery compare with others? ________

C. __Developmental History:__

At what age did this child:

Sit alone ________ Stand alone ________

Walk ________

Toilet Trained:

	Began	Completed
Bowl		
Bladder		

Has child returned to wetting at any time? ________ Explain ________
____

Has child returned to soiling at any time? ________
____

D. __Early Illnesses:__

Childhood Illnesses or Diseases	Age	Complications or Problems

High Fevers ________ Earaches ________ Mild ( ) Severe ( )
How High? ________ Ear Infections ________ Mild ( ) Severe ( )
How Long? ________
Allergies or sinus condition ________ If so, explain ________
____

Comments: ________
____

Tonsils removed? ________ Adenoids removed? ________ When ________
Severe injuries or falls ________ Ever hospitalized? ________
Why ? ________ Length of time in hospital ________
Physicians's name and address ________

Does the child have any of the following symptoms more frequently than most children?

( ) Indigestion
( ) Constipation
( ) Diarrhea
( ) Runs a temperature
( ) Seems overtired
( ) Eyestrain
( ) Weak or lacking in pep
( ) Sinus trouble
( ) Nervous spells
( ) Dizzy spells
( ) Headaches
( ) Asthma
( ) Aches and pains
( ) Hay fever
( ) Colds
( ) Vomits food
( ) Nightmares
( ) Perspires even in cool weather

Describe: ________

E. Child's Communication: (Tell how child understands and uses speech)

1. Does the child usually ask for things? ________ or point? ________
2. Does the child attempt to use speech? ________
3. Can the entire family understand the child? ________
4. Can friends and casual acquaintances understand the child? ________
5. When did your child say his first word? ________ What was it? ________
6. Approximately how many words does your child usually combine to make a sentence? ________
7. Write down a typical phrase or sentence your child says ________
8. At any time, has your child's communication drastically changed? ________
If yes, describe ________
To what do you attribute this change? ________
9. Does your child understand conversation? ________ Single words? ________
Gestures? ________

F. Ear History:

1. Has your child ever had an ear examination in an ear doctor's office?
Yes ________ No ________
If so, when? ________ By Whom? ________
2. Have you noticed signs which may indicate ear problems? Yes ________ No ________
If yes, what are they? ________
Does any type of fluid ever come from your child's ear? ________
Does your child have a heavy amount of ear wax? ________
3. Do any of the immediate members of the family have any of the ear problems mentioned in question #2? ________

4. Has there been surgery or medication for ear problems? ______ Describe: ______

______

5. Has your child ever received any medication such as Aureomycin ______
Streptomycin ______ or Sulfa? ______

6. Family History:

List relatives having hearing problems: ______

______

Causes: Otosclerosis ______ Genetic ______ Infection ______

G. Hearing Loss:

1. How long have you been aware of some hearing problems? ______
2. Do you know what may have caused the hearing loss? ______
3. Does your child complain of any "ringing" or noise in his ears? ______
4. Does your child complain of any "dizziness"? ______
Describe: ______

If "yes" to above, how often, for how long, and at any particular time? ______

______

5. Does your child wear a hearing aid? ______ If "yes" for how long? ______
6. Does your child respond to sounds in his environment? ______
7. Which ear appears to be the better ear? ______
8. Does the hearing vary from one day to the next? ______
9. Is the hearing better at any season of the year? ______
10. Has your child's hearing been tested previously? ______ Dates: ______
By Whom: ______ Address: ______

H. Eye History:

1. Has your child ever been examined by an eye doctor? ______ If so, when? ______
Doctor's name: ______ Address: ______

Ophthalmologist: ______ Address: ______

Optometrist: ______ Address: ______

2. Does your child wear glasses ? ______
3. Has your child ever worn an eye patch or had a course of visual training? ______
If "yes" please describe: ______

______

4. Has your child had eye surgery? ______ If "yes" please decribe: ______

______

5. Do the eyes look crossed or does one eye wander away from the object at which the child is looking especially when ill or tired? ______

6. Do any members of your family have crossed eyes or one eye which is weaker than the other? ______

7. Does your child take medication for eye infections or allergies ? ______

8. Does your child have eye-hand coordination problems? ______

I. Physical

Orthopedic History:

1. Describe child's physical problem: ______

2. Are you aware of the child's exact medical diagnosis? If so, please state: ______

3. What may have caused the condition? ______

4. How long has the condition existed? ______

5. Medical Specialist (s) involved in diagnosis and/or treatment of the child:

Pediatrician: ______ Address: ______
Orthopedist: ______ Address: ______
Physiatrist: ______ Address: ______
Other: ______ Address: ______

6. Treatment recommendations: ______

7. Are there any special devices needed for treatment and/or daily living (e.g., braces, catheter, aspirator, etc.)? ______

J. Check any of the below which you have observed in your child

______ Restless or overactive
______ Excitable
______ Inattentive
______ Overly sensitive, feelings easily hurt
______ Daydreams
______ Temper tantrums or outbursts
______ Irritable, prone and bickering
______ Destructive of his things or others
______ Overly bold, rude, or ill-mannered

______ Overly clinging or dependent
______ Shy, bashful, or withdrawn
______ Too easily led by others
______ Clumsy, awkward, poor coordination
______ Seeks attention, shows off
______ Sluggish, drowsy, slow in manner
______ Depressed, often sad
______ Nervous, Jittery, easily startled
______ Frequent complaints of aches or pains

Describe: ______

K. List or describe the things you like about your child's behavior: ______________

____

____

Signature ______________
Relationship ______________
Date ______________

Please contact:

EXHIBIT L

DATE: ______________

SUMMARY OF

______ INTAKE PLACEMENT STAFFING

______ CONSULTATIVE STAFFING

______ EDUCATIONAL STAFFING

Name ______________ Teacher ______________

Birthdate ______________ Level or Grade ______________

Parents ______________ Program ______________

Participants ______________________________

______________________________________.

Specific Concerns:

Pertinent Information:

Recommendations:

EXHIBIT M

Name of Child: ____________________

I.D. #: ____________________

FORMAL TEST SCORE WORKSHEET

INSTRUCTIONS: This form is to be maintained during diagnosis as an on going record of formal test results. In addition to providing information for the Diagnostic Summary, Formal Test Scores may be used as baseline measures in the Individual Behavioral Ladder and later compared to comparable post-placement data.

Name of Test	Date Tested	Scores	Comments/Interpretation

EXHIBIT N

Name of Child: ______________________

I.D. #: ______________________

INFORMAL TEST SCORE WORKSHEET

INSTRUCTIONS: This form is to be maintained during diagnosis as an ongoing record of informal test results. In addition to providing information for the Diagnostic Summary, informal test results may be used as baseline measures in the Individual Behavioral Ladder and later compared to comparable post-placement data.

Test, Checklist, Scale	Date tested	Task/Activity	Materials/Equipment	Results/Comments

EXHIBIT O

SAMPLE FORMAT FOR DIAGNOSTIC SUMMARY

A. Identifying Information

Child's Name: Sex: Birthdate:

Parents' Name:

Home Address:

Referring Agency or School:

Address of Agency or School:

Child's Current Program or Placement:

Name of Sending Teacher:

Name of Case Leader: Title:

B. Reasons for Referral In essay or outline form, briefly state the reasons the child was referred to the Diagnostic Team. List the specific questions posed by the referring person (s) and the child's parents concerning the child's diagnosis and program.

C. Statement of Major Handicapping Condition (s)

1. Developmental History This section should include any pertinent or noteworthy information concerning the child's birth and early development. Facts to include may be the mother's age at the time of birth and any unusual factors which may have complicated the delivery. Developmental stages to note may be the child's age of walking, talking, and toilet training.

2. Medical Summary This section should summarize the child's past and present medical status. Information such as diseases, accidents, and hospitalizations should be mentioned here. Included should be the names of physicians and therapists who have worked with the child prior to or during the Team diagnosis.

3. Social Summary This section should include pertinent facts relating to the child's family background, rank in the family, number of siblings, parents marital status, relationship to family, peers, and adults, socialization difficulties at home and school, and interests or hobbies.

E. Diagnostic Team Objectives List in priority sequence the objectives which the diagnostic team identified at the outset of Phase 2, Diagnosis, as guidelines for the diagnostic process.

F. Tests Administered List the formal tests that were given to the child along with the dates the tests were administered and the scores obtained.

G. Summary of Diagnostic Information by Domain This section should include a summary, by category or domain, of 1) the Diagnostic Teacher's observations of the child's strengths and weaknesses, 2) an interpretation of formal and informal tests administered to the child, and 3) observations of the child during testing. It is of particular importance that brief and concise interpretations of test scores and test performance data be given to the receiving agency or teacher.

As appropriate to the individual child, the "domains" should be inclusive of the following:

1. Motor Skills, including:
   - a. Gross motor
   - b. Fine motor

2. Sensory/Perceptual Skills, including:
   - a. Visual reception
   - b. Visual association
   - c. Visual perception
   - d. Visual motor
   - e. Auditory reception
   - f. Auditory association
   - g. Auditory perception

3. Speech and Language, including:
   - a. Articulation
   - b. Receptive language
   - c. Expressive language
   - d. Language usage

4. Academic Skills, including:
   - a. Reading skills
     - 1. Reading readiness
     - 2. Oral reading: rate and comprehension, fluency
     - 3. Silent reading: rate and comprehension
     - 4. Phonetic/word attack skills
     - 5. Spelling
   - b. Math Skills, including:
     - 1. Number identification, numeration, counting
     - 2. Basic operations: addition, subtraction, multiplication, division
     - 3. Money: coin indentification, making change

        4. Telling time
        5. Fractions, decimals, percentages, etc.

    c. Writing Skills, including:
        1. Handwriting/penmanship/letter formantion
        2. Written expression/creative writing

5. Social-Emotional Skills, including:
    a. Peer relationships
    b. Adult relationships
    c. Family relationships
    d. Self concept
    e. Behavior

6. Self-help Skills, including:
    a. Feeding
    b. Dressing
    c. Toileting
    d. Personal hygiene
    e. Mobility

H. Attachments Any reports, records, or documents which might be useful to the receiving agency or teacher should be attached. These may include medical reports, psychological evaluations, or school records.

EXHIBIT P

Name of Child: ____________________

I.D.#: ____________________

FIELD TEST WORKSHEET

INSTRUCTIONS: This form is to be used while field-testing initial program prescriptions. Enter comments and and required revisions for each prescription in the appropriate column.

Instructional Mat'ls	Equipment	Reinforcers	Learning Environment	Teaching Strategies

EXHIBIT Q

INDIVIDUAL BEHAVIORAL LADDER

INSTRUCTIONS: The Individual Behavioral Ladder consists of a series of graduated behavioral objectives established for the child at the completion of Phase 3, Program Development and Testing. It must contain, for each diagnostic domain and short range program objective, the skills and behaviors the child is to acquire, increase, maintain, decrease, and extinguish during the twelve month follow-up period. These skills and behaviors are to be obtained from the Task Analysis and Behavioral Change Plan.

The Individual Behavioral Ladder initially forms a tool for the receiving teacher to assess the effectiveness of his or her efforts in terms of the objectives set for the child. It is later used by the Case Leader, along with the Individual Behavioral Ladder Follow-Up Sheet to measure the extent to which the child has achieved the behavioral objectives and the program has proven successful. Finally, based on the information on the Follow-Up Sheet, the Individual Behavioral Ladder is revised and redistributed at 3, 6, 9, and 12 month follow-up intervals.

The Individual Behavioral Ladder should be filled in as follows:

Column I, Behavioral Objective In this column list the behavioral objectives for the diagnostic domain and Short Range Program Objective under consideration (see upper left hand corner.) The behavioral objectives are to be listed in order of increasing difficulty, and should correspond to increasing time frames in Column II. Each of the behavioral objectives must include

a) an action verb,
b) the conditions under which the behavior is to be performed, and
c) the standard to which the behavior is to be performed.

For further information on writing behavioral objectives, see Appendix, "Behavioral Objectives."

Column II, Time Frame In Column II simply check the 3 month post-placement time frame in which the child is expected to achieve the behavioral objective.

Column III, Direction In this column check the "direction" of the behavioral objective according to whether it represents a behavior the child is to acquire, increase, decrease, maintain, or extinguish.

Column IV, Baseline Performance In Column IV enter data describing the child's level of functioning in relation to the behavioral objective at the time on-site or in-classroom services are terminated. This data may consist of a behavioral count, a formal test score, an informal test score, or any other concrete measure of the speed, accuracy, quality, quantity, or frequency of the child's performance. It maybe obtained from the child's behavioral charts and the Formal and Informal Test Score Worksheets completed during Phase 2, Diagnosis.

Column V, Program Prescriptions   This column must contain a description of the instructional materials, equipment, and activities required to train the child to achieve the behavioral objective. Also included in this column may be recommendations for teaching and motivational strategies, the child's learning environment, or any other instructions, remarks, or comments useful to the receiving teacher.

The completed Individual Behavioral Ladder is to be forwarded to the child's receiving teacher, parents, and other program implementers along with the Diagnostic Summary and Individual Educational Plan.

INDIVIDUAL BEHAVIORAL LADDER

DIAGNOSTIC DOMAIN: ________________

SHORT RANGE OBJECTIVE: ________________

Name of Child: ________________

Date: ________ ID#: ________

Case Leader: ________________

____ Original

____ First Revision

____ Second Revision

____ Third Revision

I. BEHAVIORAL OBJECTIVE	II. TIME FRAME (in months)				III. DIRECTION					IV. BASELINE PERFORMANCE	V. PROGRAM PRESCRIPTIONS
	3	6	9	12	Acquire	Increase	Maintain	Decrease	Extinguish		

EXHIBIT R

SAMPLE FORMAT FOR INDIVIDUAL EDUCATIONAL PLAN

A. General Information

Child's Name: I.D. #:

Diagnostic Teacher: Date:

Case Leader:

B. Objectives

1. Summary of Long Range Program Objectives. This section should include a summary of the long range program objectives developed for the child. It should describe the skills and competencies the child should be able to acquire by adulthood in each diagnostic domain.

2. Summary of Short Range Program Objectives. This section should include a summary of the short range program objectives which have been developed for the child. It should describe the subskills the child must attain in order to meet the long range program objectives which have been previously set.

3. Summary of Behavioral Objectives. This section, based on the "Individualized Behavioral Ladder," should summarize, by domain, the behavioral objectives that have been set for the child for the 3, 6, 9 and 12 month follow-up periods. Included for each domain addressed in this section should be a statement of the rationale for the corresponding behavioral objectives.

C. Summary of Recommended Strategies. This section, which is heavily based on the "Field Test Worksheets," should include specific instructions for strategies which have been found to be particularyly effective in implementing programs for the child. As necessary, the rationale for each strategy should be indicated. Included in this section should be:

1. Teaching Strategies. This section may include specific procedures, priorities, and sequencing recommended for use by the receiving teacher or agency. It may also include general teaching guidelines for the receiving teacher such as "concentrate on remediation of the child's weak sensory channel (e.g., auditory). Use the child's strong channel (e.g.,visual) to teach subject matter." Concrete examples should be given.

Also included here should be any comments on the optimal length, complexity, and variation of assignments given to the child. Include comments regarding the degree to which the child requires independence or group or teacher involvement in completing tasks, the degree of specificity required in giving instructions to the child, etc.

2. Motivational Strategies. Included here should be:
   a. a statement of rewards and punishments which were found to particularly effective or ineffective in working with the child.
   b. a description of token systems and/or reinforcement schedules recommended for use with the child.

The importance of this section cannot be overestimated, as this information will prevent the receiving teacher or agency from having to rediscover what "makes the child tick."

3. Environmental Strategies. Included in this section should be any comments relating to the optimal learning environment for the child. For example, the child's positioning in the classroom, the type of desk or other equipment required by the child, the degree to which the child should be given mobility within the classroom, the optimal student-teacher ratio and the time of day the child functions best, may be noted.

D. Recommended Materials, Equipment, Activities. Any materials, special equipment, or activities recommended for use with the child should be listed in this section by diagnostic domain.

E. Placement Recommendations. This section should simply state the type of program and/or the name of a particular facility in the child's local district which is best suited to implement strategies and attain program objectives mentioned in the previous sections. As necessary, the rationale for the placement decision should be fully explained.

F. Recommendations for Program Implementation. This section should contain the names, titles, location, and phone numbers of resource persons, parents, and other program implementers, as well as their roles and responsibilities in program implementation.

G. Recommended Follow-Up. Included in this section should be:

1. A list of the names, titles, specialties, and phone numbers of resource persons whom the receiving agency or teacher may wish to contact for further information or clarification of existing information. The list may include appropriate local professional persons and Diagnostic Team members, as well as persons who have served the child on a contractual medical basis.

2. Recommendations for the continued involvement of Diagnostic Team members in services delivery and post-placement data collection. Time frames for future involvement, as well as the nature of the involvement (e.g., to conduct re-testing of the child, to observe the child, to work directly with the teacher and/or child, etc.) should be specified.

3. Other recommendations, such as suggestions for follow-up services provided by persons other than the Diagnostic Team, for medical re-evaluations, for additional psychological evaluations, and for follow-up social services.

H. Attachments. Any materials that might be useful to the receiving agency or teacher should be attached to the main body of the report. These might include:

1. Forms and documents compiled by the Diagnostic Team, including the Diagnostic Summary, Individual Behavioral Ladder, and other materials as necessary.
2. Social, medical, psychological, and academic reports, records, and documents.
3. A list of the questions initially posed by the referring agency and/or the child's parents and the answers to these questions.
4. Samples of materials recommended for use with the child, particularly those that are teacher-made or those that are not widely distributed.

EXHIBIT S

TEACHER FOLLOW-UP RECORD

INSTRUCTIONS: The Teacher Follow-up Record is to be completed by the Case Leader one month after the termination of Team services during a personal interview with the child's receiving teacher. The completed form must be forwarded to the Program Coordinator for use in informal program evaluation. Items 9 and 10 may also be used by the Case Leader as a comparison to identical information in the Initial Information Gathering Checklist to behavioral changes in the child since program acceptance.

A. GENERAL INFORMATION

1. Name of child:

2. Case Leader:

3. Placement:

4. Receiving Teacher:

5. Child's handicaps:

6. Services Provided (check all that apply):

   a. Contractual Medical________

   b. In-classroom:

      1. Diagnosis________

      2. Programming________

   c. On-site:

      1. Diagnosis________

      2. Programming________

      3. Consultation_______

B. Feedback

1a. To what extent have you been satisfied with the services rendered by the Diagnostic Team?

   1. Not at all______

2. To a very little extent____

3. To some extent_____

4. To a great extent______

5. To a very great extent______

6. Receiving Teacher Comments:

2a. To what extent did the Diagnostic Summary increase your understanding of the child's porblems?

1. Not at all_____

2. To a very little extent______

3. To some extent______

4. To a great extent_____

5. To a very great extent______

6. Receiving Teacher Comments:

b. Which parts were most useful and why?

c. Which parts were least useful and why?

d. What additional information would you have found useful?

3a. To what extent did you find the Individual Educational Plan helpful in the development of educational programming for the child?

1. Not at all____
2. To a very little extent_____
3. To some extent______
4. To a great extent______
5. To a very great extent_____
6. Receiving Teacher Comments:

b. Which parts were most useful and why?

c. Which parts were least useful and why?

d. What additional information would you have found useful?

4a. To what extent have you found the Individual Behavioral Ladder useful in assessing the child's progress and regression?

1. Not at all_____
2. To a very little extent_____
3. To some extent______
4. To a great extent______
5. To a very great extent______

6. Receiving Teacher Comments:

5a. To what extent did you find the training and technical assistance provided by the Diagnostic Team useful in program implementation ?

1. Not at all____
2. To a very little extent_____
3. To some extent_____
4. To a great extent_____
5. To a very great extent_____
6. Receiving Teacher Comments:

6. To what extent has the child moved toward normalization?

a. Not at all____

b. To a very little extent_____

c. To some extent_____

d. To a great extent_____

e. To a very great extent____

f. Receiving Teacher Comments:

7. To what extent were the Diagnostic Team services instrumental in the child's movement toward normalization?

a. Not at all_____

b. To a very little extent_____

c. To some extent_____

d. To a great extent_____

e. To a very great extent_____

f. Receiving Teacher Comments:

8. If applicable, to what extent has the child successfully adjusted to his or her new placement?

a. Not at all_____

b. To a very little extent______

c. To some extent______

d. To a great extent______

e. To a very great extent______

f. Receiving Teacher Comments:

9. If applicable, to what extent were the Diagnostic Team Services instrumental in effecting a smooth transition for the child into his or her new placement?

a. Not at all______

b. To a very little extent______

c. To some extent______

d. To a great extent______

e. To a very great extent______

f. Receiving Teacher Comments:

10a. In what ways has the child progressed?

b. In what ways has the child regressed?

In what ways has the child otherwise changed?

11. **List below the child's characteristic positive behaviors and their frequencies.**

Behavior	Frequency

12. **List below the child's characteristic negative behaviors and their frequency.**

Behavior	Frequency

13. Teacher Comments:

EXHIBIT T

PARENT FOLLOW-UP RECORD

Instructions: The Parent Follow-Up Record is to be completed by the Case Leader or Team Social Worker one month after the termination of Team Services during a personal interview with the child's parents. The completed form must be forwarded to the Program Coordinator for use in informal program evaluation.

Identifying Information:

Child's Name: Sex: Date: Birthdate:

Parent's Name: I.D.#:

Home Address:

Referring Agency or School:

Address of Agency or School:

Child's Current Program or Placement:

Name of Sending Teacher: Title:

Name of Case Leader: Title:

Questions:

1. To what extent did the Diagnostic Team increase your understanding of your child's problems?

   a. Not at all _______
   b. To some extent _______
   c. To a great extent _______

2. To what extent did you find the Diagnostic Team helpful in the development of a good educational program for your child?

   a. Not at all _______
   b. To some extent _______
   c. To a great extent _______

3. If applicable, to what extent was the Diagnostic Team instrumental in securing a better placement for your child?

   a. Not at all _______
   b. To some extent _______
   c. To a great extent _______

4. a. Since your child's involvement with the Diagnostic Team, what, if any, improvements have you observed in him or her in school? at home?

b. In what ways, if any, has he or she gotten worse?

5. Did you find the Diagnostic Team services helpful in any other ways? If so, please give examples.

6. Did you find the Diagnostic Team services inadequate in any way? If so, please give examples.

7. What, in your opinion, was the best thing that happended to (name of child) during his or her involvement with the Diagnostic Team?

8. Generally speaking, to what extent are you satisfied with the range and quality of services provided to your child by the Diagnostic Team?

a. Not at all ______
b. To some extent ______
c. To a great extent ______

9. Parent Comments:

DOMAIN: ______________

INDIVIDUAL BEHAVIORAL LADDER FOLLOW-UP SHEET

SHORT RANGE PROGRAM
OBJECTIVE: ______________

______ 3 Month
______ 6 Month
______ 9 Month
______ 12 Month

I. BEHAVIORAL OBJECTIVES	II. DIRECTION OF BEHAVIORAL OBJECTIVE					III. FOLLOW-UP PERFORMANCE					IV. WAS OBJECTIVE ACHIEVED AT STANDARD SPECIFIED?		V. COMMENTS (e.g., rewrit delete, retain with new time frame, etc.)
	Acquire	Maintain	Increase	Decrease	Extinguish	Acquired	Maintained	Increased	Decreased	Extinguished	Yes	No	

EXHIBIT U.

CHILD FOLLOW-UP RECORD

Date: ____________________ I.D.#: ____________________

_______ 3 Month _______ 6 Month _______ 9 Month _______ 12 Month

Instructions: This form is to be employed on a quarterly basis for one year from the date of the exit staffing. It is to be completed by the Case Leader, with assistance from the child's receiving teacher, on each child who has received in-classroom services. The information from the Child Follow-Up Record is to be used by the Case Leader in the revision of the child's Individual Behavioral Ladder and by the Program Coordinator in formal program evaluation.

A. General Information. Include the following:

Child's Name: Sex: Birthdate:

Parent's Name:

Home Address:

Referring Agency or School:

Address of Agency or School:

Child's Current Program or Placement:

Name of Sending Teacher: Title:

Name of Case Leader: Title:

B. Behavioral Ladder Follow-Up Sheet. Complete one sheet for each short range program objective. Using the Individual Behavioral Ladder, enter in Column I the corresponding behavioral objectives for the three month period under evaluation. Enter in Column II the "direction" for each objective as specified in the Individual Behavioral Ladder. Finally, complete Columns II-V in cooperation with the child's receiving teacher. Refer to the Individual Behavioral Ladder as necessary.

C. Achievement of Behavioral Objectives. Compute percentages on each of the following items.

1. General Progress.

   a. Across all diagnostic domains addressed in the Individual Behavioral Ladder, what percent of the behavioral objectives for this follow-up quarter were achieved? _______

b. For each diagnostic domain addressed in the Individual Behavioral Ladder, what percent of the behavioral objectives for this follow-up quarter were achieved?

(1) Motor Skills ____

(2) Sensory-Perceptual Skills ____

(3) Speech and Language Skills ____

(4) Academic Skills ____

(5) Social-Emotional Skills ____

(6) Self-Help Skills ____

c. For each diagnostic domain addressed in the Individual Ladder, what percent of the short range program objectives were achieved? (Compute percentage of short range program objectives for which all behavioral objectives were achieved for each diagnostic domain).

(1) Motor Skills ____

(2) Sensory-Perceptual Skills ____

(3) Speech and Language Skills ____

(4) Academic Skills ____

(5) Social-Emotional Skills ____

(6) Self-Help Skills ____

2. General Regression.

a. Across all diagnostic domains in the Individual Behavioral Ladder, for what percent of the behavioral objectives for this follow-up quarter was regression evident? (Include in this computation all behaviors that were to be 1) increased, but actually were decreased or extinguished, 2) maintained, but actually were decreased, 3) decreased, but actually were increased, maintained, or decreased. Refer to Columns II and III of the Individual Behavioral Ladder Follow-Up Sheet).

b. For each diagnostic domain addressed in the Individual Behavioral Ladder, for what percent of the behavioral objectives for this follow-up quarter was regression evident? (Compute for each domain as in 2a above).

(1) Motor Skills ____

(2) Sensory-Perceptual Skills ____

(3) Speech and Language Skills ____

(4) Academic Skills ____

(5) Social-Emotional Skills ____

(6) Self-Help Skills ____

D. Revision Information. After the child's Individual Behavioral Ladder has been revised based on Section C above, complete the following:

1. Number of objectives deleted: ____

2. Number of objectives added: ____

3. Number of objectives rewritten: ____

EXHIBIT V

LONGITUDINAL FOLLOW-UP RECORD

DATE: ____________________ ID# ____________________

INSTRUCTIONS: This form is to be completed by the Case Leader on an annual basis for each child who has received in-classroom services until the child exits from the exucational system. It is to be employed during a phone or personal interview at the end of each school year with the child's current teacher and forwarded to the Program Coordinator for use in Formal Program Evaluation.

A. GENERAL INFORMATION

1. Name of Child:
2. Case Leader:
3. Child's Current Placement:
4. Child's Current Teacher:
    - a. Name :
    - b. Phone Number:
5. Dates of Diagnostic Classroom Placement

From ____________________ to ____________________
Month/Year Month/Year

B. Interview Questions

1a. To what extent do you feel that ____________________ has advanced
name of child
toward normalization in the current school year?

(1) Not at all: ____
(2) To a very little extent: ____
(3) To some extent: ____
(4) To a great extent: ____
(5) To a very great extent: ____

b. In what ways?

2a. To what extent do you feel that ____________ (name of child) has regressed during the current school year?

(1) Not at all: ___

(2) To a very little extent: ___

(3) To some extent: ___

(4) To a great extent: ___

(5) To a very great extent: ___

b. In what ways?

3a. To what extent do you feel that ____________ (name of child) deviates from the academic and social norms for the children in your classroom?

(1) Not at all: ___

(2) To a very little extent: ___

(3) To some extent: ___

(4) To a great extent: ___

(5) To a very great extent: ___

b. In what ways?

4a. To what extent do you feel that ______________________ is failing to
name of child
reach his or her potential?

(1) Not at all: ____
(2) To a very little extent: ____
(3) To some extent: ____
(4) To a great extent ____
(5) To a very great extent: ____

b. In what ways?

C. For completion by Case Leader:

1a. How do the child's normative tests scores for the closing school year compare to those for previous years?

b. What, according to these scores, has been the nature of the child's movement toward or away from normalization?

	Academically	Socially:
(1) The child has deviated much further from the norm	________	________
(2) The child has deviated slightly further from the norm	________	________
(3) The child has advanced slightly toward the norm	________	________
(4) The child has advanced considerably toward the norm	________	________
(5) The child has achieved the norm	________	________

2. To what extent is the child achieving the Short Range Program Objectives established for him or her during Diagnostic Classroom Placement?

(1) Not at all: ______

(2) To a very little extent: ______

(3) To some extent: ______

(4) To a great extent: ______

(5) To a very great extent: ______

3. To what extent is the child achieving the Long Range Program Objectives established for him or her during Diagnostic Classroom Placement?

(1) Not at all: ______

(2) To a very little extent: ______

(3) To some extent: ______

(4) To a great extent ______

(5) To a very great extent: ______

4. Comments:

EXHIBIT W.

INFORMAL EVALUATION DATA SUMMARY SHEET

Instructions: This form is to be completed on an annual basis by the Program Coordinator, using data from the Teacher and Parent Follow-Up Records. Retain one copy and forward one copy to Dr. Harold Berjohn, Director Regional Resource Center #7, 3202 N. Wisconsin Peoria, IL 61603.

A. General Information

1.a Number of children receiving on-site services: ___

b. Handicaps of children receiving on-site services:

1. ___ No handicaps
2. ___ Retarded
3. ___ Orthopedic
4. ___ Speech Impaired
5. ___ Hearing Impaired
6. ___ Deaf
7. ___ Visually Impaired
8. ___ Blind
9. ___ Emotionally Disturbed
10. ___ Learning Disabilities
11. ___ Other (specify:) ____________

2.a Number of children receiving in-classroom services: ___

b. Handicaps of children receiving in-classroom services:

1. ___ No handicaps
2. ___ Retarded
3. ___ Orthopedic
4. ___ Speech Impaired
5. ___ Hearing Impaired
6. ___ Deaf
7. ___ Visually Impaired
8. ___ Blind
9. ___ Emotionally Disturbed
10. ___ Learning Disabilities
11. ___ Other (specify:) ____________

B. Teacher Follow-Up Data. Using the Teacher Follow-Up Records, compute the percentages of teachers indicating each of the response options for the following items:

1. Extent to which receiving teachers were satisfied with the services rendered by the Diagnostic Team (see item B.1.a on the Teacher Follow-Up Record):

		On-Site:	In-Classroom:	Total:
a.	Not at all:	___%	___%	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	___%	___%

2. Extent to which the Diagnostic Summary increased receiving teachers' understanding of the child's problems (see item B.2.a. on the Teacher Follow-Up Record):

a.	Not at all:	___%	___%	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	___%	___%

3. Extent to which receiving teachers' found the [illegible] Educational Plan helpful in the development of education programming [illegible] B.2.a. on the Teacher Follow-Up Record):

a.	Not at all:	___%	___	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	%	___%

4. Extent to which receiving teachers' [illegible] in assessing the child's progress and [illegible] Follow-Up Record):

a.	Not at all:	___%		___%
b.	To a very little extent:	___%		___%
c.	To some extent:	___%		___%
d.	To a great extent:	___%		___%
e.	To a very great extent:	___%		___%

5. Extent to which receiving teachers' found the training and technical assistance provided by the Diagnostic Team useful in program implementation (see item B.5.a on the Teacher Follow-Up Record):

		On-Site:	In-Classroom:	Total:
a.	Not at all:	___%	___%	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	___%	___%

6. Extent to which the children have moved toward normalization (see item B.6 on the Teacher Follow-Up Record):

a.	Not at all:	___%	___%	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	___%	___%

7. Extent to which Diagnostic Team services were instrumental in the chilren's movement toward normalization (see item B.7 on the Teacher Follow-Up Record):

a.	Not at all:	___%	___%	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	___%	___%

8. Extent to which children successfully adjusted to new placements (see item B.8 on Teacher Follow-Up Record):

a.	Not at all:	___%	___%	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	___%	___%

9. Extent to which Diagnostic Team services were instrumental in effecting smooth transition for children into new placements (see B.9 on Teacher Follow-Up Record):

		On-Site:	In-Classroom:	Total:
a.	Not at all:	___%	___%	___%
b.	To a very little extent:	___%	___%	___%
c.	To some extent:	___%	___%	___%
d.	To a great extent:	___%	___%	___%
e.	To a very great extent:	___%	___%	___%

C. Parent Follow-Up Data. Using the Parent Follow-Up Records, compute the percentages of parents indicating each of the response options for the following items:

1. Extent to which parents' understanding of child's problems was increased (see item 1 on Parent Follow-Up Record):

		On-Site:	In-Classroom:	Total:
a.	Not at all:	___%	___%	___%
b.	To some extent:	___%	___%	___%
c.	To a great extent:	___%	___%	___%

2. Extent to which parents found the Diagnostic Team helpful in the development of a good educational program for the child (see item 2 on Parent Follow-Up Record):

a.	Not at all:	___%	___%	___%
b.	To some extent:	___%	___%	___%
c.	To a great extent:	___%	___%	___%

3. Extent to which parents found the Diagnostic Team instrumental in securing better placement for the child (see item 3 on Parent Follow-Up Record):

a.	Not at all:	___%	___%	___%
b.	To some extent:	___%	___%	___%
c.	To a great extent:	___%	___%	___%

4. Extent to which parents were satisfied with the range and quality of Diagnostic Team services (see item 8 on Parent Follow-Up Record):

a.	Not at all:	___%	___%	___%
b.	To some extent:	___%	___%	___%
c.	To a great extent:	___%	___%	___%

EXHIBIT X.

FORMAL EVALUATION DATA SUMMARY SHEET

Date: ______________________ Program Coordinator: ______________

Instructions: This form summarizes data gathered on children who have received in-classroom services to be completed in an annual basis by the Program Coordinator, using data from the Child Follow-Up Records and Longitudinal Follow-Up Records. Retain one copy and forward one copy to Dr. Harold Berjohn, Director, Regional Resource Center #7, 3202 N. Wisconsin, Peoria, IL 61603.

A. General Information

1. Number of children receiving in-classroom services: ____

2. Handicaps of children receiving in-classroom services:

   a. ____ No handicaps
   b. ____ Retarded
   c. ____ Orthopedic
   d. ____ Speech Impaired
   e. ____ Hearing Impaired
   f. ____ Deaf
   g. ____ Visually Impaired
   h. ____ Blind
   i. ____ Emotionally Disturbed
   j. ____ Learning Disabilities
   k. ____ Other (specify)
   ____
   ____
   ____

B. Child Follow-Up Data.

Using Section C of the Child Follow-Up Records, complete percentages for each of the following items:

1. Achievement of behavioral objectives across domains: ____%

2. Achievement of behavioral objectives for each domain: ____%

   a. Motor Skills ____%
   b. Sensory-Perceptual Skills ____%
   c. Speech and Language Skills ____%
   d. Academic Skills ____%
   e. Social-Emotional Skills ____%
   f. Self-Help Skills ____%

3. Achievement of short-range program objective for each domain:

   a. Motor Skills ____%

   b. Sensory-Perceptual Skills ____%

   c. Speech and Language Skills ____%

   d. Academic Skills ____%

   e. Social-Emotional Skills ____%

   f. Self-Help Skills ____%

4. Regression across domains: ____%

5. Regression for each domain: ____%

   a. Motor Skills ____%

   b. Sensory-Perceptual Skills ____%

   c. Speech and Language Skills ____%

   d. Academic Skills ____%

   e. Social-Emotional Skills ____%

   f. Self-Help Skills ____%

6. Objectives deleted: ____%

7. Objectives added: ____%

8. Objectives rewritten: ____%

C. Longitudinal Follow-Up Data

Using the Longitudinal Follow-Up Record, complete the percentage of teachers indicating each of the response options for the following items:

1. Extent to which children advanced toward normalization (see item B.1.a on the Longitudinal Follow-Up Record):

   a. Not at all: ____%

   b. To a very little extent: ____%

   c. To some extent: ____%

   d. To a great extent: ____%

   e. To a very great extent: ____%

2. Extent to which receiving teachers' felt children had regressed during the current school year (see item B.2.a. on the Longitudinal Follow-Up Record):
    a. Not at all: ____%
    b. To a very little extent: ____%
    c. To some extent: ____%
    d. To a great extent: ____%
    e. To a very great extent: ____%

3. Extent to which receiving teachers' felt that children deviated from the other children in the classroom (see item B.3.a. on the Longitudinal Follow-Up Record):
    a. Not at all: ____%
    b. To a very little extent: ____%
    c. To some extent: ____%
    d. To a great extent: ____%
    e. To a very great extent: ____%

4. Extent to which receiving teachers' felt children were failing to reach his or her potential (see item B.4.a. on the Longitudinal Follow-Up Record):
    a. Not at all: ____%
    b. To a very little extent: ____%
    c. To some extent: ____%
    d. To a great extent: ____%
    e. To a very great extent: ____%

5. Nature of the children's movement toward or away from normalization (see item B.5.a. on the Longitudinal Follow-Up Record):
    a. Children deviated much further from norm: ____%
    b. Children deviated slightly further from norm: ____%
    c. Children advanced slightly toward norm: ____%
    d. Children advanced considerably toward norm: ____%
    e. Children achieved the norm: ____%

6. Extent to which the children are achieving the Short Range Program Objectives established for them during Diagnostic Classroom Placement?

a. Not at all: ____%

b. To a very little extent: ____%

c. To some extent: ____%

d. To a great extent: ____%

e. To a very great extent: ____%

7. Extent to which the children are achieving the Long Range Program Objectives established for them during Diagnostic Classroom Placement?

a. Not at all: ____%

b. To a very little extent: ____%

c. To some extent: ____%

d. To a great extent: ____%

e. To a very great extent: ____%

EXHIBIT Y

FEDERAL REPORTING FORM

INSTRUCTIONS: This form is to be completed by the Program Coordinator on an annual basis, using data from the Master Client Registry and Cas Contact Record, and forwarded to appropriate funding sources. The Informal and Formal Evaluation Data Summary Sheets may be attached. Retain one copy of the Federal Reporting From and forward one copy to Dr. Harold Berjohn, Director, Regional Resource Center #7, 3202 N. Wsiconsin, Peoria, Il 61603.

A. GENERAL INFORMATION:

1. Name of Program
2. District:
3. Address:
4. Name of Program Coordinator:
5. Phone Number:

Date:

Period covered in report:

from ____________ to ____________
month/year month/year

B. MASTER CLIENT REGISTRY DATA:

1. Total number of children served: ____________

2. Handicaps of children served (enter percent of total child population possessing each handicap):

   a. No Handicap ____%
   b. Retarded ____%
   c. Hard of Hearing ____%
   d. Deaf ____%
   e. Speech Impaired ____%
   f. Visually Impaired ____%
   g. Seriously Emotionally Disturbed ____%
   h. Crippled ____%
   i. Other Health Impairments ____%
   j. Hearing Disabilities ____%
   k. Multiple (specify j-k above) ____%

3. Severity of handicaps of children served (enter percent of total child population falling in each category of severity):

a. No Handicap _____%

b. Mild _____%

c. Moderate _____%

d. Severe _____%

4. Age of children served (enter percent of total child population falling in each age group):

a. Under 5 _____%

b. 5 - 15 _____%

c. Over 15 _____%

5. Services Requested (enter number and percent of total number of cases for each category):

		Number	Percent
a.	Diagnostic Classroom Placement	____	____
b.	Consultation	____	____
c.	Psychologist	____	____
d.	Social Worker	____	____
e.	Consulting Diagnostic Teacher	____	____
f.	Deaf Educator	____	____
g.	Vision Educator	____	____
h.	Other (specify)	____	____
i.	Contractual Medical (specify)	____	____
j.	Other (specify)	____	____

6. Services Provided:

a.	Diagnostic Classroom Placement	____	____
b.	Consultation	____	____

c.	Psychologist		
d.	Social Worker		
e.	Consulting Diagnostic Teacher		
f.	Deaf Educator		
g.	Vision Educator		
h.	Other		
i.	Contractual Medical		
j.	Other		

C. Case Contact Data

1. Average number of contacts per case: ______________

2. Type of contact (enter number and percent of total number of contacts for each category):

		Number	Percent
a.	Phone calls		
b.	Conferences		
c.	Staffings		
d.	Home Calls		
e.	Other		

3. Contact Persons (enter number and percent of total number of contacts for each category):

   a. School Support Staff
   b. Medical Consultants
   c. Adminstrators
   d. Sending/Receiving Teachers
   e. Parents
   f. Other Resource Person

4. Purpose of contacts (enter percent only):

a. Provide technical assistance ______%

b. Gather information ______%

c. Provide information ______%

d. Provide training ______%

e. Give demonstration ______%

f. Receive technical assistance ______%

g. Follow-up ______%

SECTION 4

HYPOTHETICAL CASE STUDY FOR THE ILLINOIS - RRC DIAGNOSTIC TEACHING MODEL

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Introduction

The purpose of the following hypothetical case study is to provide examples of the written materials produced by the Diagnostic Team during Phase 2, Diagnosis, and Phase 3, Program Development and Testing. The primary purpose of these materials is to synthesize, organize, and summarize all the diagnostic and prescriptive information collected or generated on a given child. Thus they represent the culmination of the many information-gathering and data-processing activities contained in the model.

While the hypothetical case study includes only portions of completed materials, it should nonetheless serve as a model for the content and format of written information produced on actual cases. Further explanation of these materials and their continuity in the context of the total IRDTM are contained in Section 2, "Flowcharts."

Purpose of the Diagnostic Team Objectives

The Diagnostic Team Objectives are devised at the onset of Phase 2, Diagnosis, and are based on the information collected during Phase 1, Initial Information-Gathering. The purpose of the Diagnostic Team Objectives is to establish the goals for the Diagnostic Team members during their involvement with the child in the delivery of on-site or in-classroom services. They also serve to delineate the division of labor and time frames for the Diagnostic Team and to identify the resource persons required in the diagnostic process.

Sample Diagnostic Team Objectives

Objective	Diagnostic Team Member Responsible	To Be Completed By	Resource Persons Needed
1. Eliminate self-destructive behavior	Diagnostic Classroom Teacher	Nov. 15, 1976	Psychologist
2. Determine Edward's current level of intellectual functioning	Diagnostic Classroom Teacher	Oct. 10, 1976	Psychologist
3. Determine which academic skills Edward has acquired and needs to acquire	Diagnostic Classroom Teacher	Oct 31, 1976	
4. Determine Edward's visual acuity	Consulting Diagnostic Teacher	Nov. 21, 1976	Opthomologist
5. Obtain additional information concerning Edward's inverted foot and possible recommendations for therapy		Nov. 15, 1976	Physical Therapist
6. Determine the appropriateness of current medication prescribed for hyperactivity	Consulting Diagnostic teacher	Nov. 3, 1976	Neurologist Pediatrician
7. Increase Edward's skills in verbal expression and language usage	Diagnostic Classroom Teacher	Nov. 30, 1976	Speech Therapist
8. Increase Edward's socialization skills	Social Worker Diagnostic Classroom Teacher	Nov. 30, 1976	
9. Determine the optinal learning environment and teaching strategies for Edward	Diagnostic Classroom Teacher	Nov. 30, 1976	
10. Determine Edward's motivational patterns and optimal motivational strategies	Diagnostic Classroom Teacher	Nov. 30, 1976	

Purpose of the Behavioral Change Plan

The Behavioral Change Plan, which is completed within one week after the initiation of on-site or in-classroom services, identifies the skills and behaviors the child realistically can be expected to acquire, increase, maintain, decrease, or extinguish during Phase 2, Diagnosis, and Phase 3, Program Development and Testing. It consists of a listing of behavioral objectives and for reinforcers the child and corresponding behavioral charts which are used to track the child's progress toward the achievement of the objectives.

The rationale for the Behavioral Change Plan is to facilitate the child's integration into a normal classroom environment through the development of socialization skills and the removal of disruptive or self-destructive behaviors. It thus incorporates the suggestions for behavioral change made by the child's sending teacher and parents, as well as the conclusions drawn from initial on-site observation of the child. Because behavioral change is so often brought about simply as a result of the extra attention the child receives from the Diagnostic Team, the ultimate effectiveness of the Behavioral Change Plan must be evaluated through a comparison of the pre- and post-placement observational data gathered on the child.

The Behavioral Change Plan Objectives not achieved by the child during Phases 2 and 3 may be included in the child's Individual Behavioral Ladder, which is completed at the conclusion of Phase 3.

Behavioral Change Plan Objectives

Upon exit from the diagnostic classroom, Edward will:

1. Slap himself on the head no more than once per day under normal conditions in the classroom or at home.
2. Make eye contact with the classroom teacher for at least ten seconds each time she calls his name.
3. Respond verbally using complete sentences composed of four or more words in correct order each time the classroom teacher asks him a question.
4. Given an arithmetic worksheet of 25 addition problems, sit in his chair at his desk for a period of 15 minutes without turning around, talking, throwing his pencil, or tearing the paper.
5. Voluntarily offer to share his toys with another child at least three times per week during play time.

Reinforcers to be used in conjunction with the change plan:

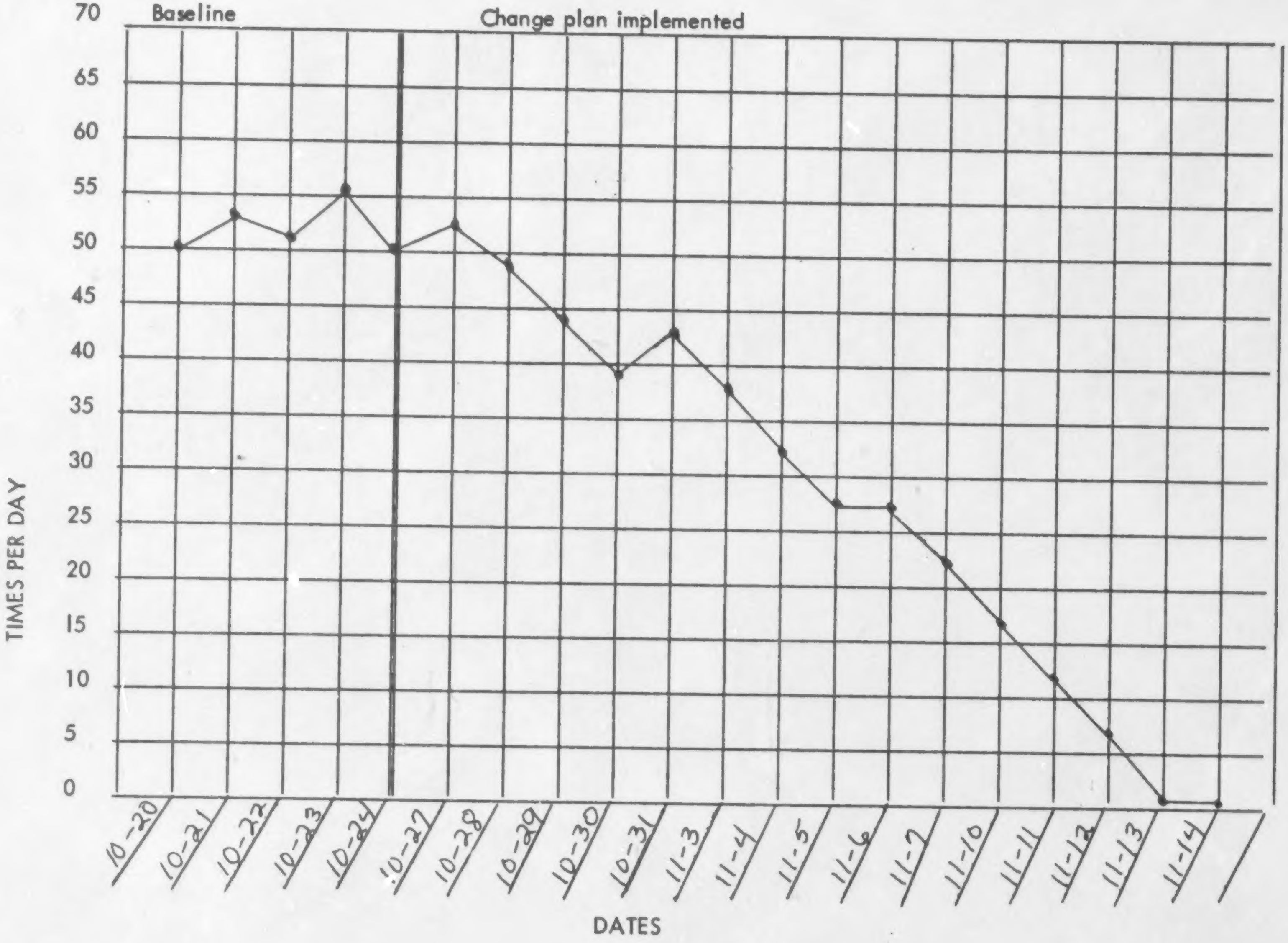
1. verbal praise
2. gold stars or "happy faces" on his worksheets
3. candy bars
4. putting puzzles together
5. use of the tape recorder
6. sitting in a rocking chair
7. feeding the fish

Behavioral Chart

Child's Name: Edward Jones

Objective #1

Slapping self



Purpose of the Diagnostic Summary

The Diagnostic Summary logically organizes and integrates the large amounts of disparate diagnostic data gathered from numerous sources during Phase 1, Initial Information-Gathering, and Phase 2, Diagnosis. As such, it represents the synthesis of all historical and current information on the total child.

The Diagnostic Summary should be attached to the child's Individual Educational Plan and forwarded to the child's receiving teacher, parents, and other persons responsible for program implementation.

SAMPLE DIAGNOSTIC SUMMARY

Child's Name: Edward Jones Sex: Male Birthdate: 5/15/66

Parent's Name: John and Sharon Jones

Home Address: 1694 W. Sunset Springfield, Ill. 61523

Referring School: Benjamin Franklin Elementary School

School Address: 1700 W. Fourth Springfield, Ill. 61525

Child's Current Program: Primary EMH

Name of Teacher: Mrs. Ruth Foster

Name of Case Leader: Thomas Smith Title: Consulting Diagnostic Teacher

Reasons for Referral

Edward was referred to the Regional Resource Center on October 14, 1976, because of his distractibility, hyperactivity, short attention span, peculiar movement patterns during excitement or tension, difficulty in comprehension and lack of dexterity. The following questions were posed by the sending school and Edward's parents:

A. School

1. At what level is Edward currently functioning intellectually and academically?
2. What is the most appropriate program for Edward?

B. Parents

1. What can be done about Edward's hyperactivity? Is the medication which is presently being given appropriate?
2. How can we control Edward's behavior at home?
3. What are Edward's abilities? disabilities?
4. What are some of the prospects for the future?

Major Handicapping Conditions

Educable Mentally Retarded

Developmental History

Edward was born at Springfield Memorial Hospital after what was apparently an uneventful labor and delivery. His weight at birth was seven pounds, fourteen ounces. He had significant problems with respiratory infections as an infant. Shortly after birth, he was noted to have inverted feet, the left one being handled by manipulation by the mother but the right one ultimately requiring the application of a short plaster cast for two months.

Some developmental lag was noted as he walked at seventeen months, talked at age three, and was toilet trained at age three and a half. Edward did not crawl; instead, he tended to move about on his back using his head and his feet, twisting his body in "snakelike" motions.

Medical Summary

Other than a tonsillectomy and adenoidectomy done in June of 1971, Edward has not been hospitalized. Records do show repeated contact with the doctor for respiratory problems, colds, inflammations of his throat, in addition to treatment for measles and chickenpox. According to Edward's medical record at Springfield Memorial Hospital, he has been formally seen at the clinic a little over 80 times in his first six years of life.

His doctor did a full musculoskeletal evaluation in 1972, and agreed that Edward had a peculiar gait which was due to internal rotation of the hips and narrow, slightly inverted feet. This condition was formally diagnosed as "internal tortion femur." For this, the doctor suggested exercises to be done in the home to work with the hips, knees and ankles. According to Mrs. Jones, these exercises were not effective and she discontinued them two weeks after the examination.

Edward has been prone to illness all of his life and Mr. and Mrs. Jones feel now that he suffers from allergies like his mother. Because of his frequent colds and allergies, Edward is either unable to or never learned to breathe through his nose.

Mr. Jones related that Edward is for the most part ambidextrous. If anything, he favors his right hand and his parents believe the only reason he favors this hand is the fact that Edward's sisters are constantly drilling him to use his right hand rather than his left.

Edward is currently taking erythrocin for high temperatures. He has been taking ritalin since he was four years old. The doctor has prescribed dimetapp elixir and aarane for his allergies.

Names of Doctors	Type	Dates
Dr. B. A. Mauzer	Pediatrician	1966-1976
Dr. J. B. Werntz	Ears, Nose, Throat	1968
Dr. John Rambo	Ears, Nose, Throat	1971 (tonsillectomy)
Dr. Theo. Hornsby	Allergist	1972
Dr. E. A. Thornton	Allergist	1974

Social Summary

Mr. and Mrs. Jones are married and living together. Edward is the youngest of three children. He has two sisters, Mary, age 14, and Susan, age 16. Mrs. Jones indicates that Edward enjoys good relationships with his parents and sisters. She characterizes him as warm, though shy with new acquaintances. Edward is easily excitable and will slap himself on the head when he becomes angry. He often bangs his head on a chair or table in order to get attention from his parents. When provoked, he howls at the individual in question.

Edward's teacher described him as inattentive, timid, lacking friends, overdependent, and excitable. The other children in the classroom tend to ignore Edward and do not invite him to join activities. Edward prefers to play alone.

At home, Edward enjoys watching television, feeding birds, riding his bicycle, and playing with his race cars.

Educational Summary

Edward was not enrolled in Kindergarten until the age of six because of medical problems and immaturity. He attended Roosevelt Elementary School in 1972-74 for Kindergarten and First Grade. He repeated First Grade in 1974-75 and was then placed in an EMH class at Benjamin Franklin Elementary School in 1975 where he is currently enrolled. While at Franklin, he received the services of a Speech Therapist approximately two times a week.

Psychological Summary

Edward was seen by the school psychologist prior to enrollment at Franklin School. He was found to be functioning in the retarded range intellectually with an I. Q. of 64 on the Stanford Binet. The examiner found him to be highly distractible and easily frustrated. He would consistently slap his head if he met with failure. Fine motor control was very weak and Edward often switched from his right hand to his left when drawing or writing.

The school psychologist recommended that the parents take Edward to see a neurologist, but the parents refused at that time.

Diagnostic Team Objectives

See list attached.

Tests Administered

Date	Name of Test	Scores Obtained
11/4/76	Peabody Picture Vocabulary Test	I. Q. 70
	Developmental Test of Visual-Motor Integration	Dv. Age 4-9
	Wepman Auditory Discrimination Test	Error Score 4

Tests Administered, Continued

Date	Name of Test	Scores Obtained
11/5/76	Illinois Test of Psycholinguistic Ability	Scaled Score
	Auditory Reception	32
	Auditory Association	12
	Auditory Memory	18
	Auditory Closure	24
	Verbal Expression	21
	Grammatic Closure	28
	Sound Blending	36
	Visual Reception	29
	Visual Association	19
	Visual Memory	34
	Visual Closure	21
	Manual Expression	21
11/6/76	Detroit Test of Learning Aptitude	Age Scores
	Verbal Absurdities	11-0
	Verbal Opposites	8-3
	Auditory Attention Unrel. Words	3-0
	Auditory Attention Rel. Syllables	3-0
	Visual Attention Span for Objects	6-6
	Visual Attention Span for Letters	6-3
	Orientation	6-9
	Memory for Designs	3-9
	Number Ability	5-9
11/7/76	Peabody Individual Achievement Test	Grade Equivalent
	Mathematics	.1
	Reading Recognition	1.3
	Reading Comprehension	1.9
	Spelling	1.6
	General Information	2.4
11/8/76	Keymath Diagnostic Arithmetic Test	Grade Equivalent
	Numeration	1.3
	Fractions	2.3
	Geometry and Symbols	2.1
	Addition	1.3
	Subtraction	0.5
	Multiplication	0.5
	Division	0.5
	Mental Computation	2.0
	Numerical Reasoning	1.3
	Word Problems	0.5
	Missing Elements	0.5
	Money	1.3
	Measurement	2.5
	Time	2.2

Tests Administered, Continued

Date	Name of Tests	Scores Obtained
11/11/76	Woodcock Reading Mastery Test	Grade Equivalent
	Letter Identification	1.0
	Word Identification	1.4
	Word Attack	1.2
	Word Comprehension	1.7
	Passage Comprehension	1.1
	Wide Range Achievement Test	
	Reading	1.5
	Spelling	1.3
	Arithmetic	1.2
	Boehm Test of Basic Concepts	1 %ile

Summary of Diagnostic Information by Domain

1. Motor Skills

Strengths: Edward enjoys physical activity and demonstrated adequate gross motor coordination when running or jumping. He has strong manipulative skills as demonstrated by the ease with which he pust puzzles together and dribbles a basketball.

Weaknesses: Those activities involving balance are difficult for Edward. He cannot balance on either foot for more than two seconds. He cannot skip. When attempting balance oriented skills, he became frustrated and refused to participate.

Edward's eye-hand coordination is poor when involved in fine motor activities. He had difficulty placing pegs in a pegboard and stringing beads.

2. Sensory-Perceptual Skills

Strengths: Edward's visual acuity or farpoint was found to be 20/20 on the Snellen Eye Test.

Hearing acuity and auditory discrimination were normal. (See audiologists report)

Weaknesses: Difficulties were found in the areas of visual-motor integration, auditory and visul memory, auditory and visual memory for unrelated objects, and visual tracking. Vertical tracking is adequate, but he cannot track objects horizontally. (See the Keystone Visual Survey attached).

3. Speech and Language

Strengths: Edward's manual expression of ideas and concepts is superior to his verbal expression. He can pantomine ideas that he cannot express verbally.

Weaknesses: Edwards's articulation was characterized by several errors. He omitted

/n/ in the medial position of words, substituted /f/ for /th/ in the final position, /bw/ for /br/ in the initial position, and distorted the /v/ sound in the word "stove." All consonants and vowels were easily imitated in isolation. Intelligibility broke down in conversational speech.

Edward consistently omits articles, nouns, and some verb forms. He usually uses very short sentences of three or four words and often confuses the sequence of words. He gets very frustrated when he cannot express himself and will sometimes stop what he is saying and shout "Stop!"

Academic

Reading Skills

Strengths:
Edward can:
- identify and write the letters of the alphabet
- give the sound for all consonants
- give the sound for long vowels
- read some sight words - I, can, cat, baby, blue, and, up, down, my, mother, house, red

Weaknesses:
Edward cannot:
- give the short vowel sounds for e, i, o, u
- tell a story in sequence
- track smoothly from left to right when reading
- use phonetic skills for word attack
- tell a story by looking at a picture
- associate objects that go together

Math Skills

Strengths:
Edward can:
- recognize and write numerals from 0-10
- adequately make 1-1 correspondence
- rotely count to 20
- tell time by the hour
- add one digit numerals from 1-5
- recognize and give the value of a penny, nickel, dime
- subtract using concrete objects

Weaknesses:
Edward cannot:
- correctly identify numerals past 10
- add or subtract using numbers greater than 5
- make change
- tell time by half hour, quarter hour, minute
- read a calendar
- use a ruler

Writing Skills

Edward can write all letters in isolation using cursive writing, but he cannot connect them properly when forming words. Spacing is poor and he often reverses b, d, p, q.

Due to his poor sight vocabulary, Edward can only write words that he copies from the blackboard. He does not write a complete sentence.

Social/Emotional

Behavior which has been observed upon entrance in the Diagnostic Classroom includes:

1. Edward would shout "Stop!" when he became frustrated. Initially, this might occur 20-25 times per day.
2. Upon entering the classroom, Edward would go to the table in the corner and look at magazines. He refused to join in group activities with other children.
3. Edward would not allow any physical contact by the teacher or other children. This would also cause him to shout "Stop!"
4. Edward has shown some self destructive behavior such as slapping his face or banging his head on the table.
5. His self concept appears to be poor as he will often say, "I dumb" when he cannot complete a task.

Self-help Skills

Strengths: Edward can adequately dress and undress himself. He has no difficulty feeding himself or using the bathroom.

Weaknesses: Edward often came to school with dirty hands, face, neck, etc. He does not brush his teeth properly, He has difficulty tying his shoes and usually wears loafers so he can avoid this. Edward still walks up and down the stairs one step at a time holding on to the railing.

Purpose of the Long Range Program Objectives

The development of Long Range Program Objectives is the first step in Phase 3, Program Development and Testing, and is based on the in-depth evaluation of the child accomplished during Phase 2, Diagnosis. The Long Range Program Objectives are comprised of a statement of the levels of functioning that the child may be expected to achieve in each diagnostic domain by the time he or she reaches adulthood. Their purpose is to insure that subsequent steps in Phase 3, including the development of program prescriptions, behavioral objectives, and placement recommendations, take into full consideration the skills and competencies the child should eventually acquire.

The extent to which the child progresses toward achievement of the Long Range Program Objectives is investigated during Phase 5, Follow-up, through the use of the longitudinal follow-up component of the Formal Evaluation (or Child Tracking) System.

SAMPLE LONG RANGE PROGRAM OBJECTIVES BY DOMAIN

Motor

Edward will be able to use a lawn mower to cut the grass.

Sensory/Perceptual

Edward will be able to listen to and follow a series of directions.

Speech/Language

Edward will initiate and carry on a meaningful conversation with members of his family, peers, and adults.

Academic

Reading: Edward will be able to read and understand road signs, directional or other instructional signs, job applications, other forms, and newspapers.

Mathematics: Edward will be able to apply basic mathematical skills necessary for daily life (e.g. telling time, making change, adding a column of multiple digits, etc.)

Writing: Edward will be able to write his name, compose simple letters, fill out job applications, and other forms.

Social/Emotional

Edward will be able to appropriately plan and use his leisure time.

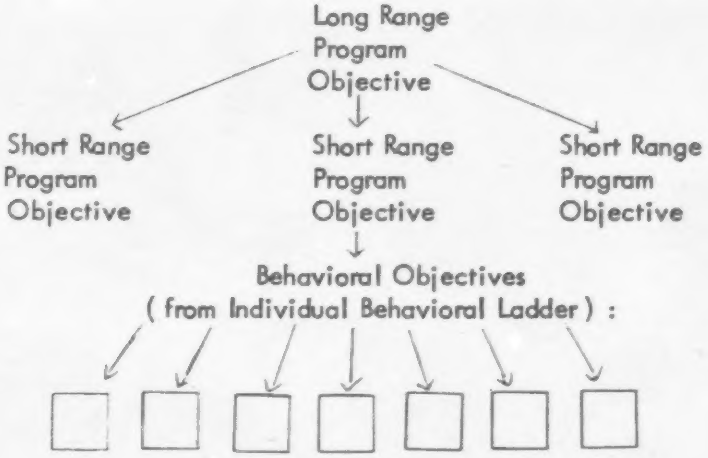
Self-Help

Edward will be able to wash, dry, and iron his own clothes.

Purpose of the Short Range Program Objectives

The Short Range Program Objectives, which are derived from the Long Range Program Objectives, specify the general skills and subskills that the child must acquire prior to achieving the Long Range Objectives. They thus act as a link between the future goals for the child and the tasks the child must master in the course of program implementations. The Short Range Program Objectives also form the foundation for the Task Analysis and the Individual Behavioral Ladder. The use of these objectives in this manner ensures that the behavioral objectives established for the child have meaning in terms of the child's eventual integration into the adult world.

The relationship between Long Range Program Objectives, Short Range Program Objectives, and behavioral objectives may be schematically depicted as follows:


Long Range Program Objective
Short Range Program Objective
Short Range Program Objective
Short Range Program Objective
Behavioral Objectives
(from Individual Behavioral Ladder) :

The extent to which the child achieves the Short Range Program Objectives is assessed during Phase 5, Follow-Up, through the use of the Formal Evaluation (or Child Tracking) System.

SAMPLE SHORT RANGE PROGRAM OBJECTIVES BY DOMAIN

Motor

Edward will be able to use simple hand tools such as a hammer, saw, screwdriver, and hand drill.

Sensory/Perceptual

Edward will demonstrate his ability to visually track an object from left to right.

Speech/Language

Edward will correctly articulate the /th/ sound during spontaneous conversation.

Academic

Reading: Edward will be able to read a story orally from a third grade reading book with 85% comprehension.

Mathematics: Edward will be able to add or subtract numbers with multiple digits.

Writing: Edward will be able to write a complete sentence using correct punctuation.

Social/Emotional

Edward will voluntarily participate in group activities both in the classroom and at home.

Self-Help

Edward will improve his personal hygiene by brushing his teeth, bathing, changing his clothes, and combing his hair daily.

Purpose of the Task Analysis

A Task Analysis is performed on each of the Short Range Program Objectives to isolate the specific tasks and behaviors the child must master before he or she can attain the Short Range Objectives. It consists simply of a sequential listing of these tasks and behaviors. Standard behavioral checklists, behavioral inventories, and developmental scales may be used in the Task Analysis, although the tasks selected from them should be modified as necessary to reflect the response capabilities, levels of functioning, and developmental sequence of the individual child.

The completed Task Analysis is used first in the selection of initial program prescriptions --*i.e.*, in determining the instructional materials, learning environment, and teaching strategies that will best enable the child to perform the desired tasks. It is used again, after the program prescriptions have been tested and revised, in the design of the child's Individual Behavioral Ladder. Thus the Task Analysis might be viewed as an initial listing of many of the behaviors which, in the Individual Behavioral Ladder, are presented as behavioral objectives and tied to specific program prescriptions.

SAMPLE TASK ANALYSIS

Short Range Program Objective to be Achieved

Edward will be able to read a story from a third grade reading book orally with no pronounciation errors and 85% comprehension.

Task Analysis

In order to achieve the short range program objective cited above, Edward must be able to:

1. maintain adequate visual and auditory acuity.
2. visually discriminate shapes (e.g. circle, square, etc.)
3. visually discriminate letters and words.
4. auditorily discriminate environmental sounds.
5. discriminate the sounds of isolated letters and words.
6. identify and name all letters of the alphabet
7. form the sound/symbol relationship for each letter.
8. develop left to right progression.
9. blend letter sounds into words.
10. identify words that have the same sound in initial, medial or final positions.
11. develop a sight word vocabulary.
12. know the meanings of the words he can identify by sight.
13. read words in phrases.
14. read words in sentences.
15. read paragraphs.
16. sequence major events in a story.
17. pick out factual detail in a story.
18. start with a primer level reading book and progress until objective is met.

Purpose of the Individual Behavioral Ladder

The Individual Behavioral Ladder is completed after the program prescriptions have been selected, tested, and revised during Phase 3, Program Development and Testing. The purpose of the Individual Behavioral Ladder is to provide to program implementers a means of planning for and gauging the child's purposeful progress toward specific ends. Thus it contains, for each diagnostic domain, the Short Range Program Objectives and behavioral objectives the child is expected to achieve during the twelve months following the termination of on-site or in-classroom services. In addition, it ties these behavioral objectives to specific instructional materials and other program prescriptions recommended to facilitate the child's achievement.

Incorporated into the Individual Behavioral Ladder are many of the tasks isolated during the Task Analysis, as well as the Behavioral Change Plan Objectives not achieved during Phases 2 and 3.

The Individual Behavioral Ladder is attached to the Diagnostic Summary and Individual Educational Plan and distributed to the child's parents, receiving teacher, and other persons involved in program implementation. The child's achievement of the behavioral objectives is evaluated during Phase 5, Follow-Up, through the use of 3, 6, 9, and 12 month Child Follow-Up, which is part of the Formal Evaluation System of the IRDTM. For each of these three month time frames, the baseline data on the Individual Behavioral Ladder is compared to the child's follow-up performance and a determination is made as to whether or not the child achieved the behavioral objectives at the standard specified. This information is used in the revision of the Individual Behavioral Ladder, which is then redistributed to program implementers.

SAMPLE

INDIVIDUAL BEHAVIORAL LADDER

DIAGNOSTIC DOMAIN: Language

SHORT RANGE OBJECTIVE: Follows simple oral directions

Name of Child: Edward Jones

Date: Nov. 10/76 ID#: 156

Case Leader: Thomas Smith

X Original
First Revision
Second Revision
Third Revision

I. BEHAVIORAL OBJECTIVE	II. TIME FRAME (in months)				III. DIRECTION					IV. BASELINE PERFORMANCE	V. PROGRAM PRESCRIPTIONS
	3	6	9	12	Acquire	Increase	Maintain	Decrease	Extinguish		
Upon hearing a series of three directions, verbalized by the teacher, Edward will carry out each in proper sequence within one minute after the directions are given.	X					X					Let's Learn Sequence Instructo Corporation Language of Directions Alexander Graham Bell Associati The following sequence of activit was used: 1. practicing directionality (left-right) 2. directions given by teacher 3. teacher demonstrates tasks 4. Edward carries out tasks 5. teacher gives direction 6. Edward repeats 7. Edward carries out directions

Date: 11/27/76

SAMPLE INDIVIDUAL EDUCATIONAL PLAN

Child's Name: Edward Jones

ID#: 156

Date of Birth: 5/15/66

Date of Referral: 10/14/76

Date of Classroom Placement: 10/28/76

Date of Classroom Exit: 11/30/76

Objectives

1. Summary of Long Range Program Objectives.

It is not unreasonable to expect Edward to be functioning adequately in several areas by adulthood. His motor skills, both gross and fine, will be at a sufficient level to enable him to move freely in his environment and to actively participate in recreational activities.

Both hearing and visual acuity are presently normal, although recent reports from optometrists indicate a shift to near-sightedness which eventually may need to be corrected with glasses.

Edward can be expected to comprehend oral language and carry on appropriate and spontaneous conversations with his family and friends. He may still rely, however, on gestures to communicate his ideas, particularly when conversing with persons who are unfamiliar to him.

Academically, we can expect Edward to acquire the skills necessary to carry out everyday activities such as reading road signs, directions, job applications, newspapers, and magazines. He should be able to manage money, make a budget, and compute basic mathematical problems.

Although Edward will continue to have difficulty expressing his thoughts in writing, he will be able to compose personal letters and fill out job applications and questionnaires if he has assistance.

Finally, Edward will develop sufficient skills to enable him to function independently in most situations. He is able to maintain good personal hygiene, care for personal belongings, and demonstrate appropriate social behavior when interacting with other people. He will need assistance in securing and maintaining living quarters, finding appropriate employment, and other higher level tasks such as filing tax returns and obtaining life or medical insurance.

2. Summary of Short Range Program Objectives.

Short term goals must be set annually for Edward to insure achievement of the long range objectives mentioned above. For the upcoming school year, Edward needs to concentrate on acquiring the following skills:

a. using hand tools in a safe and appropriate manner;

b. initiating conversation and voluntarily contributing to classroom discussions;

c. following simple oral directions;

d. voluntarily interacting with peers in play activities;

e. reading stories at the third grade level with 85% comprehension;

f. adding and subtracting mathematical problems with multiple digits;

g. developing good grooming habits;

h. working independently.

3. Summary of Behavioral Objectives.

The following behavioral objectives have been established for Edward and are expected to be achieved no later than 12 months after his exit from the Diagnostic Classroom. Refer to the Individual Behavioral Ladder for specific time frames.

a. Edward will look at a clock and be able accurately to tell the teacher what time it is each time he is asked.

b. Given a set of flash cards with one word from the Dolch List of Basic Sight Words written on each, Edward will read each word orally within five seconds after it is shown, missing no more than 10% of the total group of words.

c. Each time he is given an assignment, Edward will sit in his chair at his desk for 15 minutes without talking, kicking his feet, or throwing objects.

d. During the last ten minutes of each school day, Edward independently will button his coat, tie his shoes, and say "Goodbye" to the teacher before he leaves the classroom.

e. Edward will be able to write his full name in cursive writing on lined paper with proper letter formation, letter connections, and spacing. No letter will go above the top line or below the bottom lines.

Summary of Recommended Strategies

1. Teaching Strategies.

Material should be presented visually as much as possible since this appears to be Edwards's stronger learning channel. Concepts should be presented by incorporating concrete materials that Edward can manipulate. Tasks should include an integration of all senses so that Edward is looking, listening, and touching at the same time. Gradually reduce the visual stimuli as Edward's listening skills increase.

Edward prefers to communicate through gestures, and this should be allowed while his language skills are developing. Edward responds best to questions which require a simple one word answer, or activities which require him to point to an answer.

Include Edward in as many small group activities as possible and encourage him to respond verbally. He is fascinated by machines and works quite well with a tape recorder or Language Master. He should be given independent activities where he has an opportunity to use this equipment.

It is recommended that academic and non-academic tasks be carefully structured and that clearcut goals be set for Edward. Time should be set aside each morning and afternoon to talk with him about upcoming activities of the day.

There is a need for consistent discipline in the classroom. Although Edward has a strong need for warmth and praise from the teacher, he also needs to have limits set and he needs to be made aware of these limits. He should be allowed to formulate rules for his own behavior in the classroom. A list of these rules could then be taped to his desk as a constant reminder.

Academic tasks should last no longer than 15 minutes. Assignments should be kept to one page or worksheet at a time and gradually increased as Edward's academic skills develop. Instructions must be concise and direct. It is important that Edward repeat a series of directions to the teacher after they have been given to insure his understanding of them.

2. Motivational Strategies.

Edward is convinced that he can do no right and asks for the teacher's verbal approval at least ten times a day. It is recommended that simple tasks which Edward can do in the classroom such as coloring, giving the date, or watering plants, be selected to provide him with opportunities to assume responsibility and experience success. He should be praised while doing these tasks. Positive reinforcement for the smallest accomplishment is imperative.

Edward responds well to gold stars or "happy faces" on his papers when he finishes a worksheet correctly. After Edward has been given an assignment and is certain of the instructions, his requests for approval should be ignored until the task is completed.

A token system was implemented to increase Edward's participation in group activities. He received a token each time he spoke to another student during play time, offered to share a toy, or played with another child for ten minutes without leaving the play area. At the end of play time (a ten minutes period), these tokens could be traded for a cookie (1 token), a candy bar (3 tokens) or five minutes of individual activity of his choice (5 tokens).

Edward's strongest reinforcers were found to be verbal praise, puzzles, five minutes in a small rocking chair, and feeding the fish. He will work independently to finish these tasks in order to earn these privileges.

3. Environmental Strategies.

It is strongly recommeded that Edward be in a highly structured classroom situation. He works best in a self-contained classroom with no more than ten children in the class. At this point, Edward cannot tolerate a great deal of change, so a rigid daily schedule of activities is recommended.

Edward's hyperactivity is manifested in nervous habits such as slapping his head, wringing his hands, and turning in his chair. These behaviors increase when he is required to attend to one task for more than 15 minutes, assignments are too complex, or other children are moving around the classroom. It is strongly recommended that Edward be worked with in a setting that has minimal distraction. He works best in isolation behind a screen or in a study carrel. Visual and auditory stimuli should be kept to a minimum as he is easily distracted by noise and movement around him.

Because Edward tires easily in the afternoon, a shortened school day is recommended. If this is not feasible, a rest period should be incorporated in his daily schedule.

Summary of Recommeded Materials, Equipment, and Activities

The following materials and equipment were found to be highly effective for Edward:

Domain:	Title/Author:	Publisher:
Motor:	Daily Sensorimotor Training Activities William Brady, Geraldine Konecki, Catherine Leidy	Educational Action, Inc. 1937 Grande Avenue Baldwin, N.Y. 11510
	Move-Grow-Learn	Follett Educational Corporation 1010 W. Washington Rd. Chicago, IL 60607
Sensory/Perceptual:	Michigan Tracking Program	Ann Arbor Press 610 S. Forest St. Ann Arbor, MI 38104
	Parquetry Blocks	Ideal School Supply Co. 11000 S. Lavergne Ave. Oak Lawn, IL 60453
	Dubnoff School Program	Teaching Resources Corp. 100 Boylston St. Boston, Mass. 02116
Speech and Language:	Language Master	Bell and Howell Co. 7100 McCormick Blvd. Chicago, IL 60645

	Peabody Language Development Kit: Level #2	American Guidance Service Publishers Building Circle Pines, Minn. 55104

Academic:

Reading: The linguistic approach was found to be highly effective. This approach concentrates on the development of word attack skills through the use of word patterns---three letter words using the same short vowel sound. These are suppliemented by irregular words taught as sight words in order to produce sensible sentences and add interest.

	Merrill Linguistic Readers	Charles E. Merrill Co. 1300 Alum Creek Drive Columbia, Ohio 43216
	Palo Alto	Harcourt, Brace, Jovanovich Co. 757 Third Avenue New York, N.Y. 10017
Math:	Cubical Counting Blocks	Milton Bradley Co. Springfield, Mass. 01101
	Moving-Up in Numbers	DLM, Inc. 7440 Natchez Avenue Niles, IL 60648
	Structural Arithmetic H. G. Sterns	Houghton Mifflin Co. 1900 S. Batavin Ave. Geneva, IL 60134
Writing:	Multi-Sensory Alphabets	Ideal School Supply Co. 11000 S. Lavergne Ave. Oak Lawn, IL 60453
	Write and See	Lyons and Carnahan, Inc. 407 E. 25th Street Chicago, IL 60616

Placement Recommendations

It is recommended that Edward return to the Primary EMH class at Benjamin Franklin School. He should continue to receive the services of the Speech Therapist housed in that school.

As Edward's independence, communication, and socialization skills increase, placement in the EMH resource room should be considered. When that time comes, he should be scheduled in as many regular non-academic classes (e.g., Physical Education, Music, Shop) as possible.

Recommendations for Program Implementation

1. Carol Lee, Speech Therapist at Benjamin Franklin School, should continue to work with Edward on articulation and verbal communication.

2. Edward's parents should be encouraged to continue his physical therapy sessions at Springfield Memorial Hospital under the supervision of the Physical Therapist, Ms. Phyllis Campbell. If this therapy is continued, Edward's inverted feet will be corrected. Mrs. Campbell may be reached at 752-1174.

3. Edward's parents have agreed to assist Edward in the development of his socialization skills by enrolling him in appropriate YMCA activities and by discouraging the dependency behaviors and encouraging the independent behaviors described in the behavioral objectives. Mr. and Mrs. Jones have been trained by the Consulting Diagnostic Teacher in simple behavior management techniques and seem to have a full grasp of them.

Recommended Follow-Up

1. Thomas Smith, Consulting Diagnostic Teacher, will continue to make monthly classroom observations of Edward for the remainder of the 1976-77 school year. He will also assist the receiving teacher in program implementation on an as-needed basis.

2. Carol Harding will conduct re-testing of Edward's strengths and weaknesses in reading and math no later than June 4, 1977.

3. Mike Watkins, Team Social Worker, will arrange for a physical examination with Edward's pediatrician and parents during the summer, with special attention to reviewing Edward's need for ritalin.

The following is a list of resource persons to contact if clarification or additional data is desired:

Carol Harding
School Psychologist
1315 S. Elementary
Springfield
752-7729

Dr. O. J. Wilkins
Neurologist
901 N. Third
Springfield
752-2116

Phyllis Campbell
Physical Therapist
Easter Seals
210 N. Oak
752-1002

Carol Lee
Speech Therapist
Raymond School
Springfield
752-7010

Adele Ray
Assistant Director
Regional Diagnostic Classroom
1706 N. Elm
Springfield
752-1073

SECTION 5
APPENDICES

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APPENDIX A
RRC JOB DESCRIPTIONS

TITLE: ASSISTANT DIRECTOR, REGIONAL RESOURCE CENTER (RRC, USOE, BEH, DHEW, PL 91-230, Title VI Section 621, 84 Stat. 181)

REPORTS TO: Director for Regional Programs

SUPERVISES: Regional Resource Center Staff

PRIMARY FUNCTION: Coordinate Regional Resource Center

RESPONSIBILITIES:

1. Serve as liaison staff person between Regional Resource Center personnel and central administrative personnel of District #150, the Department of Special Education, ISU, and the IOE.
2. Serve as liaison staff person between Regional Resource Center personnel and the administrative personnel of the Mid Central Association Special Education Cooperative.
3. Coordinate, on an as-needed basis, multidisciplinary intake, placement, consultative and educational staffings for Regional Resource Center students.
4. Provide inservice training programs and workshops for Regional Resource Center personnel.
5. Coordinate the Regional Resource Center personnel in educational diagnoses, research data gathering, prescriptive processes, parent education and dissemination of information.
6. Assist in the making of necessary reports as required by District #150, the Illinois Office of Education, and the U.S. Office of Education.
7. Assist the Director of the Regional Resource Center in evaluation of the personnel performance of personnel assigned to the Regional Resource Center.
8. Perform other duties and assume other responsibilities as may be assigned by the Director of the Regional Resource Center.

TITLE: TEAM CAPTAIN, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Assume responsibility for leadership and case-related decision making within the team.

RESPONSIBILITIES:

1. Call, preside over, and coordinate, on an as-need basis, multidisciplinary intake, consultative, and educational staffings, for RRC students; take notes as required.
2. Gather case-related material prior to assignment of the case leader - past records, psychologicals, etc.
3. Assume responsibility for the flow of case information and files within RRC.
4. Assist in the coordination of educational diagnosis, research data gathering, prescriptive processes and parent education.
5. Act as liaison between RRC and MCA referral agent, schools, etc. prior to assignment of case leader.
6. Communicate the professional concerns of the team as a whole to the appropriate Director and Assistant Director.

TITLE: DIAGNOSTIC CLASSROOM TEACHER, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide clinical-diagnostic teaching and programming and follow-up for students served by the Regional Resource Center

RESPONSIBILITIES:

1. Develop, through the use of diagnostic instruments, scales, histories, teaching probes and clinical judgment, a descriptive diagnosis of each RRC student's learning abilities and disabilities.

2. Prepare educational prescriptions for RRC students.

3. Participate in multidisciplinary intake, placement, consultative and educational staffings for RRC students on an as-needed basis.

4. Plan and supervise activities of diagnostic aide assigned to RRC classroom.

5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

6. Serve as a consultant to teachers and parents concerning academic and behavioral adjustment of RRC students.

7. Provide demonstrations to educate parents, teachers, and teacher aides to the educational needs of RRC students.

8. Conduct follow-up on RRC students placed in programs.

9. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.

TITLE: CONSULTING DIAGNOSTIC TEACHER, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to RRC. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the fields of mentally handicapped, learning disabled, emotionally disturbed and behaviorally disordered. Conduct diagnosis of, and devise instructional strategies and curricula for, RRC students.

2. Respond to RRC referrals from classroom teachers requesting consultation and assistance on educational and/or behavior management techniques.

3. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students on an as-needed basis.

4. Act as a substitute in the RRC diagnostic classrooms.

5. Secure materials to assist the classroom teachers upon request.

6. Conduct preliminary on-site screening of children referred for diagnostic classroom placement to insure that the referred child presents problems indicative of intensive evaluation to determine program needs.

7. Conduct on-site evaluations and/or make recommendations when the referred child does not present problems requiring intensive evaluation in the diagnostic classroom.

8. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

9. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.

10. Provide coordinative case management and follow-up services as assigned by RRC team.

11. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.

TITLE:	EDUCATOR: VISION IMPAIRED, REGIONAL RESOURCE CENTER
REPORTS TO:	Director and Assistant Director, Regional Resource Center
PRIMARY FUNCTION:	Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to RRC. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the field of vision impairment as it pertains to the diagnosis of, and development of instructional techniques and curricula for, RRC students.

2. Screen referred children to determine need for vision services. Interpret results and explain recommendations of visual examinations.

3. Provide hands-on diagnostic work (screening, evaluating and programming) in the RRC classroom and at local sites on an as-needed basis.

4. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students on an as-needed basis.

5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

6. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.

7. Provide coordinative case management and follow-up services as assigned by RRC Team.

8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.

TITLE: EDUCATOR: HEARING IMPAIRED, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to Regional Resource Center. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the field of hearing impairment as it pertains to the diagnosis of, and development of instructional techniques and curricula for, RRC students.
2. Screen referred children to determine need for speech and language services. Interpret results and explain recommendations of audiological and speech and language evaluations.
3. Provide hands-on diagnostic work (screening, evaluating and programming) in the RRC classroom and at local sites on an as-needed basis.
4. Participate in multidisciplinary intake, placement, consultative, educational staffings for RRC students on an as-needed basis.
5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.
6. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.
7. Provide coordinative case management and follow-up services as assigned by RRC Team.
8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.

TITLE: SCHOOL PSYCHOLOGIST, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide psychological services to students served by the Regional Resource Center

RESPONSIBILITIES:

1. Provide, on an as-needed basis, individual psychological services aimed at alleviating behavioral and/or adjustment problems of students served by the RRC.
2. Conduct, on an as-needed basis, individual psychoeducational case studies to assess academic and behavioral potential of RRC students.
3. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students.
4. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.
5. Serve as consultant to RRC team members, other professionals, and parents in areas of professional expertise.
6. Provide coordinative case management and follow-up services as assigned by RRC Team.
7. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.

TITLE: SCHOOL SOCIAL WORKER, REGIONAL RESOURCE CENTER

REPORTS TO: Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide social work services to students served by the Regional Resource Center, provide case management, serve as "Team Captain" for RRC staff functions, and maintain records on RRC referrals.

RESPONSIBILITIES:

1. Provide, on an as-needed basis, individual social case work services aimed at alleviating social and/or emotional problems of students served by the RRC.
2. Serve as a liaison between the RRC staff and the families of RRC students.
3. Participate and assume "Team Captain" role, in multidisciplinary intake, placement, consultative, and educational staffings for RRC students.
4. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.
5. Serve as consultant to RRC team members, other professionals, and parents in areas of professional expertise.
6. Maintain case control records and records for Child Tracking System.
7. Provide coordinative case management and follow-up services as assigned by RRC Team.
8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.

TITLE:	SPEECH THERAPIST, REGIONAL RESOURCE CENTER
REPORTS TO:	Director and Assistant Director, Regional Resource Center
PRIMARY FUNCTION:	Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to RRC. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the fields of speech and/or hearing as relates to the diagnosis of, and development of instructional techniques and curricula for, RRC students.

2. Screen referred children to determine need for speech therapy and services of deaf educator. Interpret results and explain recommendations of speech and language evaluations.

3. Provide hands-on diagnostic work (screening, evaluating, and programming) in the RRC classroom and at local sites on an as-needed basis.

4. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students on an as-needed basis.

5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

6. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.

7. Provide coordinative case management and follow-up services as assigned by RRC team.

8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.

TITLE:	TEACHER AIDE, REGIONAL RESOURCE CENTER
REPORTS TO:	Diagnostic Classroom Teacher and Assistant Director, Regional Resource Center
PRIMARY FUNCTION:	Provide in-classroom assistance to diagnostic classroom teacher.

RESPONSIBILITIES:

1. Assist Diagnostic Teacher in the conduct of formal and informal assessment and testing.
2. Assist Diagnostic Teacher in the trial implementation of prescriptive programming.
3. As necessary, provide special transportation for RRC students and/or their families.
4. Provide child care services (feeding, diapering, toilet training, etc.) as assigned by Diagnostic Classroom Teacher.
5. Perform other duties as assigned by Diagnostic Classroom Teacher and Assistant Director of the Regional Resource Center.

TITLE: CLERK-TYPIST, REGIONAL RESOURCE CENTER

REPORTS TO: Assistant Director, RRC

PRIMARY FUNCTION: Provide clerical services for the Regional Resource Center Staff

RESPONSIBILITIES:

1. Process correspondence for RRC Assistant Director, including dictation, transcription, composition and typing.
2. Process professional reports and correspondence for RRC staff.
3. Process all business forms, including travel requests, purchase orders, annual personnel evaluations, etc.
4. Process all project required reports and other general word processing.
5. Maintain a high level of professional expertise and flexibility in all interactions with project clients, and any other job related contacts.
6. Perform such other tasks and assume clerical responsibilities as may be assigned by the RRC Assistant Director and/or Director.

APPENDIX B
SUGGESTED QUALIFICATIONS FOR DIAGNOSTIC TEACHERS

Appendix B

SUGGESTED QUALIFICATIONS FOR DIAGNOSTIC TEACHERS

The following narrative presents a number of recommendations for selection criteria for Diagnostic Classroom Teachers and Consulting Diagnostic Teachers. This information was obtained during the course of nine "master performer" interviews conducted with Diagnostic and Special Education teachers from the Peoria Public School System during the week of March 2 - 6, 1976. The interviews were conducted by Reuben Chapman and Kirsten Preston of VIA, Inc.

The following are the recommendations made by the interviewers with respect to 1. education, 2. experience, 3. knowledge, 4. aptitude/orientation, and 5. skill requirements for diagnostic teachers:

1. Education

The Diagnostic Teacher ideally should possess multiple certifications in several of the Special Education sub-specialties, including Learning Disabilities (LD), Educable Mentally Handicapped (EMH), Trainable Mentally Handicapped (TMH), Behavior Disorders (BD), Emotionally Disturbed (ED), and Early Childhood Education. Early Childhood Education was singled out for particular attention because it is one of the more unusual sub-specialties and because many of the children served by the RRC, regardless of chronological age, present emotional and academic skill levels that are normative for pre-school children. For each of the above areas in which the candidate for Diagnostic Teacher lacks certification, it was recommended that he or she possess substantial experience either in an "hands-on" setting or as a consultant to such a "hands-on" setting. In regions in which a Consulting Diagnostic Teacher is also employed, competence in these areas of expertise may be shared.

2. Experience

With regard to experiential requirements it was recommended that the Diagnostic Teacher possess experience with children with a wide range of ages and handicaps. Emphasized in this connection was experience with orthopedically handicapped children. It was also strongly recommended that the teacher have concrete experience in strictly diagnostic settings, in the delivery of "hands-on" individualized instruction, and in prescription writing.

3. Knowledge

The Diagnostic Teacher should possess a broad theoretical background in special education in general and the individualization of instruction and observation techniques in particular. Also mandatory are a thorough knowledge of psychological tests, developmental scales and instructional materials.

4. Aptitude/Orientation

A number of required aptitudes for the Diagnostic Teacher also emerged from the interviews. First, the Diagnostic Teacher should possess an aptitude for intense, short-term periods of working with a child, as opposed to the less intense, longer-range involvement typical of more normal classroom settings. This implies an ability to "let go," or to find job and/or personal satisfaction in diagnosis and prescription rather than in program implementation.

Also of great importance is an aptitude on the part of the Diagnostic Teacher for teamwork, as well as a non-threatening, non-authoritative manner. The latter is particularly significant in view of the fact that the Diagnostic Teacher must be able to obtain the assistance of potentially resistant receiving teachers.

Finally mentioned as necessary aptitudes for Diagnostic Teachers were high levels of frustration tolerance and persistence, due to the frequency with which behavior problems and slow-learners (or seeming "non-learners") are encountered and the frequent need to try a number of diagnostic and prescriptive tools before any degree of success is attained. As one interviewee stated, the Diagnostic Teacher must be either an "optimistic realist or realistic optimist."

With regard to teacher orientation, two recommendations were made. First, the Diagnostic Teacher must have a "non-faddist," yet eclectic, frame of reference. Interviewees agreed that this orientation is a necessity in dealing with individualized diagnosis and programming for the child population served by the RRC.

Secondly, the teacher must possess a viable strategy for "cracking" a given case, as well as a strong and positive rationale for this strategy. The strategy most often mentioned in the interviews was first, to assume that success on the child's part is possible and is the team responsibility; second, to define through diagnosis the child's strengths, weaknesses, and learning channels; and finally, to field-test an instructional program intended ro remediate weak learning channels while inputting academic materials through the strong channels. However, it was agreed that it was not the content of the strategy itself, but rather its being geared to positives in the child that was most critical.

5. Abilities and Skills

Interviewees cited the following as the abilities and skills required by Diagnostic Teachers:

a. Ability to individualize diagnosis and prescription, including the ability to view the child apart from any set of norms or standards; the ability to choose from a wide range of diagnostic and prescriptive tools those appropriate to the individual child; the ability to measure the child's progress against himself; and the ability to use theory eclectically.

b. Skill in the use of observational techniques, especially in identifying those subtle verbal and non-verbal behaviors and environmental factors which are often ignored but may nonetheless comprise valuable sources of diagnostic data.

c. Skill in the use of developmental scales.

d. Skill in the interpretation of formal test results and the translation of the test results into meaningful statements about the child's handicaps and required remediation or programming.

e. Skill in the synthesis of large volumes of disparate diagnostic data.

f. Skill in task analysis including breaking diagnostic categories into subcategories, subskills and tasks which may be incorporated into behavioral objectives.

g. Skill in writing behavioral objectives.

h. Skill in interpersonal communications in both teacher-child interactions and teacher-team interactions.

i. Skill in team-building and the management of human resources.

j. Skill in modifying prescriptive recommendations to reflect on-site reality constraints.

APPENDIX C
ALTERNATIVE REPLICATION STAFFING MODELS

ALTERNATIVE REPLICATION STAFFING MODELS

Due to regional variations in population, existing programs, and resources available for replication, the Diagnostic Classroom Model will be reproduced at various sites with different program emphases and at different levels of complexity. The following narrative presents 1) the minimum team and supportive staff requirements for model replication, and 2) eight alternative staffing models for potential adoption by replicating regions. Each of the models may be modified to reflect regional constraints and strengths; however, it is strongly recommended that the minimum requirements are met whenever possible.

Minimum Requirements for Model Replication

There follows a discussion of the minimum diagnostic and supportive staff required for implementation of the Diagnostic Classroom Model.

1. Diagnostic Classroom Teacher. Full-time availability of a Diagnostic Classroom Teacher is required to staff the diagnostic classroom (see Diagnostic Classroom Teacher job description, p.271).

2. Teacher Aide. Full-time employement of a Teacher Aide to assist in diagnostic classroom activities is highly desirable; half-time is the minimum requirement. (See Teacher Aide job description, p. 278).

3. Consulting Diagnostic Teacher. The part-time services of a Consulting Diagnostic Teacher are required to respond to referrals, to conduct screening of children referred for diagnostic classroom placement, and to deliver on-site services to children in schools served by the Diagnostic Team (see Consulting Diagnostic Teacher job description, p.272). These job duties may in smaller regions be combined with those of the Program Coordinator (see #4 below).

4. Program Coordinator. This staff person should be minimally available on a part-time basis to perform general administrative duties, to manage the Child Tracking System, and to act as a substitute for the Diagnostic Classroom Teacher. (For a listing of administrative duties, see the job description for Assistant Director, RRC, p.269). In smaller regions, the responsibilities of the Program Coordinator may be assigned to the Consulting Diagnostic Teacher (see #3 above). In regions in which it is not possible to employ a Consulting Diagnostic Teacher, it will be neccesary for the Diagnostic Classroom Teacher to perform many of these administrative and consultative functions. However, it is strongly recommended that at least one part-time combination Program Coordinator/Consulting Diagnostic Teacher be employed in each region.

5. Team Social Worker. The Team Social Worker must be available on at least a part-time basis to deliver social work services to the students and families served by the Diagnostic Team (see School Social Worker job description, p.276).

6. Team Psychologist. As with the Team Social Worker, a Team Psychologist must be available at least part-time to conduct psychological evaluations and provide individual psychological services to children served by the Diagnostic Team (see School Psychologist job description, p. 275).

7. Team Specialists. It is necessary for the Diagnostic Team to have ongoing, daily access to the consultative services of several team specialists, including a Deaf Educator, Vision Educator, and Speech Therapist. Access to a Media Specialist is also recommended. (See Team Specialist job descriptions, p.273). The types of team specialists employed in replicating regions will depend on local program strengths as well as on the certifications and experience of other team personnel.

8. Medical Personnel and Other Consultants. To ensure that the Diagnostic Team is able to assess all aspects of the children they serve, it is mandatory that the services of medical and other consultative personnel be arranged as the need is indicated. (A listing of the types of consultants required by the Diagnostic Team appears in "Consultants Available to the RRC Team," p. 277). Funding for the use of medical services should be arranged through local sources whenever possible. In the event that local sources of funding are exhausted, requests for Direct Service Funds may be forwarded to the Regional Resource Center (see Memo RE: Use of Direct Service Funds, p.).

Alternative Replication Staffing Models

There follows a series of options for replication of the Diagnostic Classroom Model. The first five models concern the levels of staffing which may be arranged for those diagnostic classrooms scheduled for operationalization in September, 1976. The sixth, "expanding" model proposes the use of one or more Consulting Diagnostic Teachers fully trained in the Diagnostic Classroom Model and responsible for coordination and implementation of the model in local Special Education Districts. The seventh and eighth models are sequential in that they allow for the gradual development of the replication effort during FY 76-77 and full classroom implementation during FY 77-78.

It is strongly recommended that regions choose to implement one of the first five models for the following reasons: 1) to maintain uniformity in the replication effort, 2) to ensure the availablity of technical assistance from the Regional Resource Center, and, 3) to ensure access to Direct Service Funds through the Regional Resource Center. While it is anticipated that the RRC will continue beyond its current contract, this funding does expire in January, 1977.

Regardless of which model is adopted, it should be noted that student-teacher ratio should exceed 2:1, or 4:2, including the Teacher Aide.

DIAGNOSTIC CLASSROOM STAFFING MODELS

Type I. This skeletal staffing model allows for the operation of a single diagnostic classroom and minimizes the extent to which on-site services may be provided to schools served by the Diagnostic Team. The model also assumes that the Diagnostic Classroom Teacher will perform many of the functions ideally assigned to the Program Coordinator and Consulting Diagnostic Teacher.

Staff	Status
Diagnostic Classroom Teacher	Full-time
Teacher Aide	Full or part-time
Team Social Worker	Part-time
Team Psychologist	Part-time
Team Specialists	Ongoing access
Medical and Other Consultants	Contracted or arranged as-needed

Type II. With the addition of a combination Program Coordinator/Consulting Diagnostic Teacher and the expanded use of the Team Social Worker, Psychologist, and Specialists, this model allows for the increased delivery of both on-site and in-classroom diagnostic and prescriptive services. As with the Type I model, it pertains to a single classroom.

Staff	Status
Diagnostic Classroom Teacher	Full-time
Teacher Aide	Full-time
Program Coordinator/ Consulting Diagnostic Teacher	Full-time
Team Social Worker	Full or part-time

Team Psychologist	Full or part-time
Team Specialists	One full-time, or two part-time, and/or ongoing access
Medical and Other Consultants	Contracted or arranged as needed

Type III. This model, which is comprised of one fully staffed classroom, a fully staffed team, and a full-time administrator, provides for maximal delivery of on-site and in-classroom diagnostic and prescriptive services. It differs from Type II primarily in its increased emphasis on the delivery of on-site psychological, social work, and specialty services.

Staff	Status
Diagnostic Classroom Teacher	Full-time
Teacher Aide	Full-time
Program Coordinator	Full-time
Consulting Diagnostic Teacher	Full-time
Team Social Worker	Full-time
Team Psychologist	Full-time
Team Specialists	Two or three full-time
Medical and Other Consultants	Contracted or arranged as needed

Type IV. The Type IV model accommodates two diagnostic classrooms. While the composition of the Diagnostic Team in this model is the same as in Type III, additional emphasis is placed on services delivery to children placed in the diagnostic classrooms. The Regional Resource Center is staffed in accordance with the Type IV model.

Staff	Status
Diagnostic Classroom Teachers	Two full-time
Teacher Aides	Two full-time
Program Coordinator	Full-time
Consulting Diagnostic Teacher	Full-time

Team Social Worker	Full-time
Team Psychologist	Full-time
Team Specialists	Two or three full-time
Medical and Other Consultants	Contracted or arranged as needed

Type V. This model is identical to the Type IV model except insofar as it allows for multiple classrooms and multiple teams. At least one fully staffed Diagnostic Team should be provided for every two diagnostic classrooms.

Staff	Status
Diagnostic Classroom Teacher	One full-time per classroom
Teacher Aide	One full-time per classroom
Program Coordinator	One full-time
Consulting Diagnostic Teacher	One full-time per two classrooms
Team Social Worker	One full-time per two classrooms
Team Psychologist	One full-time per two classrooms
Team Specialists	Two or three full-time per two classrooms
Medical and Other Consultants	Contracted or arranged as needed

Type VI. The Type VI "expanding" model assumes the full-time exployment during FY 76-77 of one or more Consulting Diagnostic Teachers whose functions are: 1) to train previously identified Special Education Teachers in the use of the Diagnostic Classroom Model, 2) to manage the formation of the Diagnostic Team, 3) to provide ongoing consultation, and 4) to monitor the functioning of participating classrooms.

Type VII. This sequential model postpones the operationalization of the diagnostic classroom (s) until September, 1977. It consists simply of one or more Consulting Diagnostic Teachers whose responsibilities are to sell the model to local school systems, to coordinate the establishment of diagnostic classrooms, and to train team members in the Diagnostic Classroom Model.

Type VIII. Type VIII is also a sequential model; however, it proposes the establishment in September, 1976 of a "model" diagnostic classroom and Diagnostic Team (Type II, III, or IV) to be replicated within the region during FY 77-78. In this scheme, the Program Coordinator and/or Consulting Diagnostic Teacher is responsible for selling the model and coordinating the regional replication effort.

It is anticipated that one of these models will be adopted for use in each replicating region and further tailored to reflect the resources of the region.

APPENDIX D
CONSULTANTS AVAILABLE TO THE RRC TEAM

Appendix D

CONSULTANTS AVAILABLE TO THE RRC TEAM

In the context of the RRC Diagnostic Classroom Model, the term "consultant" is used to designate any individual contacted by RRC team members to provide information on, or services to, children served by the RRC.

Consultative services are obtained from many settings: public clinics, private practices, hospitals, public or private counseling and mental health agencies, school systems, court systems, etc. Generally speaking, the services of physicians in private practice are purchased through Direct Service Funds; consultation with other professional and paraprofessional personnel, who either have worked with the child, will work with the child ,or can provide assistance in assessment and programming, are simply arranged. The nature of contacts made with consultants has ranged from brief phone calls (e.g., to clarify a technical term or test score) to extended conferences (e.g., for exploration or confirmation of a diagnosis or prescription).

There follows a listing of a variety of professional personnel whose services are available to the RRC Diagnostic Team. The consultants most often used by the team are family physicians, pediatricians, psychiatrists, neurologists, physical therapists, occupational therapists, school psychologists, speech therapists, and school social workers.

This list of consultants is by no means exhaustive. It should be noted in particular that not included on the list are a number of potential consultants whose services are not typically purchased, but who nonetheless are invaluable sources of diagnostic data, such as the child's sending teacher, previous teachers, teacher aides, volunteers, parents or guardians, siblings, etc. It should also be noted that considerable crossover occurs between the general categories listed below (e.g., a family physician may give insight into the social-emotional as well as the medical problems of a child).

CONSULTANTS AVAILABLE TO THE RRC TEAM:

Medical Consultants

1. Physicians, including family physicians, pediatricians, neurologists, orthopedic surgeons
2. Nurses
3. Occupational therapists

Cognitive Consultants

1. Psychologists, including school and developmental psychologists
2. Diagnosticians and psychometrists
3. Psychiatrists

Hearing Consultants

1. Otologists
2. Audiologists
3. Speech therapists
4. Nurses

Vision Consultants

1. Ophthamologists
2. Optometrists
3. Vision educators
4. Nurses

Educational Consultants

1. Psychologists, including school and developmental psychologists
2. Diagnosticians and psychometrists

Social-Emotional Consultants

1. Psychologists
2. Social workers (school, court, welfare, private agency, etc.)
3. Psychiatrists
4. Family counselors/therapists

APPENDIX E

BIBLIOGRAPHY OF DIAGNOSTIC TESTS

BIBLIOGRAPHY OF DIAGNOSTIC TEST APPENDIX E

MOTOR

Crawford Small Parts Dexterity Test. John Crawford and Dorthea Crawford. Psychological Corp., 1956. A performance test designed to measure fine motor coordination. Age Range: youth - adult. Time: 15 minutes.

Goodenough - Haris Draw - A - Person Test. Dale B. Harris. Harcourt, Brace, Jovanovich, 1963. Individual or group test of intellectual maturity and motor development using children's drawings of human figures. Age Range: 3-6 to 13-6. Time: 5-15 minutes.

Hand-Tool Dexterity Test. George Bennett. Psychological Corp., 1965. A measure of proficiency in using ordinary mechanics' tools. Age Range: youth - adult. Time: untimed.

Harris Test of Lateral Dominance. Psychological Corp. Test to show right or left preference with hand, eye, foot. Age Range: six and over. Time: untimed.

Lincoln - Oseretsky Motor Development Scale. William Sloan. Western Psychological Services, 1954. Individual test involving a wide variety of gross and fine motor skills. Age Range: 6-14. Time: 20-30 minutes.

Motor Problems Inventory. Glyndon D. Riley, Ph.D. Western Psychological Services. Measures gross and fine motor coordination, laterality. Age Range: 3-12. Time: 5-10 minutes.

Movement Skills Survey. R. E. Orpet, Ed.D. and T. L. Heustis, M.A. Follett Publishing Co. A list to help assess a child's motor development. Age Range: 3-8.Time: untimed.

Oseretsky Tests of Motor Proficiency. Edgar A. Doll. American Guidance Service, Inc. Individual test of motor development. Age Range: 4-16. Time: 20-30 minutes.

Stromberg Dexterity Test. Eleroy Stromberg. Psychological Corp., 1951. Rates arm and hand movements of workers. Age Range: youth and adult. Time: 20-30 minutes.

SENSORY/PERCEPTUAL

VISUAL

Benton Visual Retention Test. Arthur Benton. Psychological Corp. Individually administered test of ability to draw designs from memory. Age Range: 8 - adult. Time: 5-10 minutes.

Developmental Test of Visual-Motor Integration. Keith Beery. Follett Publishing Co., 1967. A visual-motor test of the child's ability in copying designs. Age Range: 2-15. Time: 10-15 minutes.

Frostig Developmental Test of Visual Perception. Marianne Frostig. Follett Publishing Co., 1966. Measures abilities in the areas of eye-hand coordination, figure-ground discrimination, shape constancy, position in space, and spatial relations through group or individual administration. Age Range: 4-8. Time: 30-40 minutes.

Keystone Visual Survey. Keystone View Co. Individually administered screening device to assess visual acuity, depth perception, and binocularity. Age Range: 5-adult. Time: 15 minutes.

Pre-Tests of Vision, Hearing and Motor Coordination. W. W. Clark, E. R. Sullivan, and E. W. Tiegs. California Test Bureau. Age Range: 5-adult. Time: 15 minutes.

Purdue Perceptual-Motor Survey. Eugene Roach and Newell Kephart. Charles E. Merrill Publishing Co., 1966. A series of tests for assessing perceptual-motor skills including body image, form perception, balance, and ocular control. Age Range: 6-10. Time: 30-45 minutes.

Slosson Drawing Coordination Test. Richard Slosson. Slosson Educational Publication, 1967. Designed to identify perceptual disorders where eye-hand coordination is involved. Age Range: 1-12. Time: 5-10 minutes.

Southern California Test Battery for Assessment of Dysfunction. A. Jean Ayres, Ph.D. Western Psychological Services, 1962. A battery containing the following tests which can be purchased separately: Southern California Kinesthesia and Tactile Perception Tests; Southern California Figure-Ground Visual Perception Test; Southern California Motor Accuracy Test; Southern California Perceptual-Motor Tests; and the Ayres Space Test. Age Range: 4-11. Time: 20 minutes - 1 hour.

AUDITORY

Auditory Memory Span Test. Joseph M. Wepman, Ph.D. and Ann Morency. Western Psychological Services, 1973. A test to assess the level of development of ability to retain and recall familiar words. Age Range: 5-8. Time: 10 minutes.

Goldman-Fristoe-Woodcock Auditory Discrimination Test. Ronald Goldman, Ph.D., Macalyne Fristoe, Ph. D., and Richard W. Woodcock, Ed.D. American Guidance Service, Inc., 1970. Tests speech sound discrimination under quiet and noisy conditions. Age Range: 4-adult. Time: 15-20 minutes.

Goldman-Fristoe-Woodcock Auditory Skills Test Battery. Ronald Goldman, Ph.D., Macalyne Fristoe, Ph.D., and Richard W. Woodcock, Ed.D. American Guidance Service, Inc., 1974. Twelve tests of auditory skills including auditory discrimination, auditory memory and auditory figure-ground. Age Range: 3-adult. Time: 10-20 minutes.

Kindergarten Auditory Screening Test. Jack Katz, Ph.D. Follett Publishing Co. Identifies young children who have auditory perception difficulties. Grade levels: K-1. Time: 20 minutes.

Lindamood Auditory Conceptualization Test. Charles H. Lindamood and Patricia C. Lindamood. Teaching Resources. Measures child's ability to discriminate one speech sound from another and to perceive the number and order of sounds in sequence. Age Range: preschool-adult. Time: 10 minutes.

Test of Nonverbal Auditory Discrimination. Norman Butenica, Ph.D. Follett Publishing Co., 1975. Individual or group test which taps discrimination of pitch, loudness, rhythm, duration and timbre. Grade levels: K-2. Time: 15-20 minutes.

Wepman Auditory Discrimination Test. Joseph M. Wepman, Ph.D. Western Psychological Services, 1958. Individually administered test of discrimination of 40 word pairs. Age Range: 5-9. Time: 5-10 minutes.

SPEECH AND LANGUAGE

Ammons Full-Range Picture Vocabulary Test. Psychological Corp. Measures receptive vocabulary. Age Range: 3 - adult. Time: 15-20 minutes.

Assessment of Children's Language Comprehension. Foster, Gidden, and Stark. Consulting Psychologist Press, Inc., 1967. Age Range: 2-6. Time: 10-15 minutes.

Brown-Carlsen Listening Comprehension Test. Harcourt,Brace,Jovanovich. A receptive language test designed for group use. Age Range: 13-18. Time: 30 minutes.

Detroit Test of Learning Aptitude. Harry Baker and Bernice Leland. Bobbs-Merrill Co., Inc., 1935, 1959, 1967. An individual test which taps verbal abilities, attention, memory, and reasoning abilities. Age Range: 4-adult. Time: 45 minutes - 1 hour.

Houston Test of Language Development. Margaret Crabtree. Houston Test Co., 1963. Assesses several areas of general language development. Age Range: 18 months - 6 years. Time: 20-30 minutes.

Illinois Test of Psycholinguistic Abilities. Samuel Kirk, Winifred Kirk, and James McCarthy. University of Illinois Press, 1968. An individually administered test which delineates areas of difficulty in communication and language processing. Age Range: 2 years, 6 months to 10 years, 3 months. Time: 1-1½ hours.

Northwestern Syntax Screening Test. Laura Lee. Northwestern University Press, 1969, 1971. Individually administered test of receptive and expressive language. Age Range: 3-8. Time: 20 minutes.

Peabody Picture Vocabulary Test. Lloyd M. Dunn. American Guidance Service, Inc., 1965. An individually administered test of receptive language vocabulary and intelligence. Age Range: 2-18. Time: 10-15 minutes.

Preschool Language Scale. Irla Lee Zimmerman, Violette G. Steiner, and Roberta L. Evalt. Charles E. Merrill Publishing Co., 1969. Measures auditory comprehension and verbal ability. Ages: 3-8. Time: untimed.

Slingerland Screening Test for Identifying Children with Specific Language Disability. Beth R. Slingerland. Educators Publishing Service, 1970. Group or individual screening test which taps listening, memory, and visual-motor skills. Grade Levels: 1-4. Time: 30-45 minutes.

Templin-Darley Test of Articulation. Mildred Templin and Frederick Darley. Bureau of Educational Research and Service, 1960. Subject either reads a sentence or finishes a stimulus sentence using corresponding pictures. Age Range: 4-adult. Time: varied.

Verbal Language Development Scale. Marlin J. Mecham. American Guidance Service, Inc., 1958. Uses the Informant-Interview Method. It yields a language age equivalent based on a child's level of communication. Age Range: 1 month - 16 years. Time: untimed.

Utah Test of Language Development. Marlin J. Mecham, J. Jax, and J. Jones. Communication Research Association, Inc., 1967. Test of language abilities and skills. Age Range: 4-15. Time: 30 minutes.

ACADEMIC

INTELLIGENCE AND GENERAL ACHIEVEMENT

Arthur Point Scale of Performance. Grace Arthur, Ph.D. Stoelting Co., 1925. Individually administered series of performance tests. Age Range: 5-15. Time: varied.

California Test of Mental Maturity. E. Sullivan, W. Clark, and E. Tiegs. California Test Bureau, 1951. Contains language and non-language sections. Age Range: 5-adult. Time: 1 hour.

Chicago Nonverbal Examination. Andrew W. Brown. Psychological Corp., 1963. Designed specifically for those children who are handicapped in the use of the English language. Age Range: 6-adult. Time: 25 minutes.

Lorge-Thorndike Intelligence Test. Irving Lorge and Robert Thorndike. Houghton-Mifflin Co., 1954. Provides a verbal and nonverbal battery. Grade Levels: K-college. Time: 1 hour.

Metropolitan Achievement Test. W. Durost, H. Bixler, G. Hildreth, K. Lund, and J. Wrightstone. Harcourt, Brace,Jovanovich, 1959, 1973. A battery of group tests which measure areas of reading, spelling, arithmetic, and study skills. Grade Levels: K-12. Time: varied.

Minnesota Preschool Scale. Stoelting Co. A series of 26 short subtests which provide an estimate of verbal and non verbal intelligence. Age Range: 1 year, 6 months to 6 years. Time: 30 minutes.

Peabody Individual Achievement Test. Lloyd Dunn and Frederick Markwardt. American Guidance Service, Inc., 1970. Measures reading recognition, reading comprehension, mathematics, spelling and general information. Grade Levels: K-12. Time: 30-40 minutes.

Pictoral Test of Intelligence. Joseph French. Houghton-Mifflin Co., 1964. An individual test of general ability suitable for handicapped children. Grade Levels: 3-8. Time: 45 minutes.

Slosson Intelligence Test. Richard Slosson. Slosson Educational Publications, 1963. An individually administered screening test to determine approximate IQ's. Age Range: preschool-adult. Time: 10-20 minutes.

SRA Primary Mental Abilities. L.L. Thurstone and Thelma Thurstone. Science Research Association, 1947. Group intelligence test designed to measure verbal meaning, number facility, reasoning, perceptual speed, and spatial relations. Age Range: 5-adult. Time: 30 minutes to 1 hour.

Test of Concept Utilization. Richard L. Crager, Ph.D. Western Psychological Services, 1973. Individually administered test which assesses 5 areas of conceptual thinking. Age Range: 4½-8½. Time: 10-15 minutes.

Wide Range Achievement Test. J. Jastak, S. Bijou, and S. Jastak. Western Psychological Service, 1965. A short individual test of word recognition, spelling and arithmetic. Age Range: 5-adult. Time: 20 minutes.

ACADEMIC READINESS

Analysis of Readiness Skills, Reading and Math. Mary C. Rodrigues, William H. Vogler, and James T. Wilson. Houghton-Mifflin Co. Grade Levels: K-1. Time: 30 minutes.

Boehm Test of Basic Concepts. Ann Boehm. Psychological Corp., 1969. Designed to measure mastery of concepts necessary for achievement in the first years of school. Group or individual. Grade Levels: K-2. Time: 20-40 minutes.

Early Identification of Learning Disabilities. Wretha Petersen. Special Child Publications, 1970. Individually administered test which taps, fine motor coordination, memory, following directions, and general language skills. No norms. Age Range: 4-7. Time: 30-40 minutes; varies.

First Grade Screening Test. John Pate and Warren Webb. American Guidance Service, Inc., 1969. Group test to identify potential learning problems. Taps perceptual-motor, vocabulary, social adjustment, and general information. Grade Levels: K-1. Time: 30-45 minutes.

Metropolitan Readiness Test. G. Hildreth, N. Griffith, and Mary McGauvran. Harcourt,Brace,Jovanovich, 1965. Group or individual test evaluating word meaning, matching, alphabet, listening, numbers, and copying. Grade Levels: K-1. Time: 30-60 minutes.

Preschool Attainment Record. Edgar Doll. American Guidance Service, Inc., 1966. Subtests include physical, social, and intellectual areas of functioning. Age Range: 3-6. Time: untimed.

Pupil Record of Educational Behavior. Ruth Cheves. Teaching Resources. Informal check of language, fine-motor, gross motor, and general readiness skills. No norms. Age Range: 3-10.

READING

Botel Reading Inventory. Morton Botel, C.L. Holsclaw, and G. C. Commarota. Follett Publishing Co., 1961. A group of tests to determine a variety of reading skills. such as: word recognition, comprehension, word attack skills, and word opposites. Grade Levels: 1-4. Time: 50 minutes.

Davis Reading Test. F. B. Davis and C. C. Davis. Psychological Corp. 1956, 1962. Used to check reading comprehension skills. Grade Levels; 8-13. Time: 40 minutes.

Dolch Basic Sight Word Test. Dolch. Garrard Press, 1942. List of sight words grouped by 220 easy words and 220 harder words. Grade Levels: 1-6. Time: untimed.

Doren Diagnostic Reading Test of Word Recognition Skills. Margaret Doren. American Guidance Service, Inc., 1956. Subtests include letter identification, beginning sounds, vowels, ending sounds, sight words, and blending. Group or individual. Grade Levels: 1-6. Time: 20 minutes.

Durrell Analysis of Reading Difficulty. Donald Durrell. Harcourt, Brace, Jovanovich, 1955. Designed to observe faulty habits and weaknesses in reading. Checks oral and silent reading, comprehension, listening comprehension, spelling and word analysis. Grade Levels: 1-6. Time: 30-90 minutes.

Durrell Reading-Listening Series. Donald D. Durrell, Mary T. Hayes, Mary B. Brassard. Harcourt Brace Jovanovich, 1970. Group tests of listening and reading ability. Grade Levels: 1-9. Time; 30 minutes.

Gates-MacGinitie Reading Tests. Arthur I. Gates and Walter H. MacGinitie. Western Psychological Services. A group test designed for silent reading. Grade Levels: 1-12. Time: 50 minutes.

Gates-McKillop Reading Diagnostic Tests. Arthur I. Gates and Anne S. McKillop. Western Psychological Services. Tests oral reading, word perception, blending word parts, oral vocabulary and auditory discrimination. Grade Levels: 1-12. Time:

Gilmore Oral Reading Test. Harcourt, Brace, Jovanovich. An oral reading test individually administered which gives information about word accuracy, rate and comprehension. Grade Levels: 1-8.

Gray Oral Reading Test. William S. Gray and Helen M. Robinson. Western Psychological Services. Individually administered oral reading test that combines rate and accuracy. Grade Levels: 1-12. Time: 50 minutes.

Harrison-Stroud Reading Readiness Test. Lucille Harrison and James Stroud. Houghton-Mifflin Co., 1956. The subtests include using symbols, visual discrimination, auditory discrimination, giving letter names, and using the context. Grade Level: K-1. Time: 20 minutes.

Individual Reading Placement Inventory. Edwin Smith and Weldon Bradtmueller. Follett Publishing Co., 1969. Subtests include word recognition, word analysis, oral paragraph reading, listening comprehension and auditory discrimination. Grade Levels: 1-7. Time: 20 minutes.

McCullough Word-Analysis Test. Constance M. McCullough. Western Psychological Services. Group or individual test of word analysis skills. Grade Level: 4-6. Time: untimed.

Monroe Diagnostic Reading Test. Marian Monroe. Stoelting Co. Identifies the specific difficulties of a child's reading ability. Grade Level: 1-10.

Monroe Reading Aptitude Test. Marian Monroe. Houghton-Mifflin, Group administered test to determine reading readiness. Grade Level: K-1. Time: 30 minutes.

Nelson-Denny Reading Test. M. J. Nelson and E. C. Denny. Houghton-Mifflin Co., 1929, 1960. Measures vocabulary, reading comprehension and reading rate. Grade Levels: 9-adult. Time: 30 minutes.

Nelson Silent Reading Test. M. J. Nelson. Houghton-Mifflin Co., 1931, 1962. 100 word vocabulary test which measures ability to comprehend meaning. Grade Levels: 3-9. Time: 30 minutes.

Phonovisual Diagnostic Test. Lucille Schoalfield and Josephine B. Timberlake. Phonovisual Products, Inc., 1958. Grade Levels: 3-12. Time: 15 minutes.

Roswell-Chall Auditory Blending Test. Florence Roswell and Jeanne S. Chall. Essay Press. Individually administered short tests to assess ability to hear and blend sounds to say words. Grade Levels: 2-6. Time: 10 minutes.

Slosson Oral Reading Test. Richard Slosson. Slosson Educational Publications, 1963. Word recognition. Child reads lists of words aloud to determine reading level. Grade Level: K-12. Time: 5-10 minutes.

Spache Diagnostic Reading Scales. George Spache, Ph. D. California Test Bureau, 1963. Measures oral reading, silent reading, and comprehension. Grades: 1-8. Time: 20-30 minutes.

Traxler High School Reading. Arthur E. Traxler. Bobbs-Merrill, 1967. Tests continuous reading and locating main ideas. Grade Levels: 10-12. Time: 40 minutes.

Woodcock Reading Mastery Tests. Richard W. Woodcock, Ed.D. American Guidance Service, Inc., 1973. An individually administered test of letter identification, word recognition, word analysis, word comprehension and passage comprehension. Grade Levels: K-12. Time: 20-30 minutes.

MATH

Arithmetic Achievement Tests. William E. Kline and Harry J. Baker. Bobbs-Merrill. Designed to measure mathematical achievement in computational skills. Grade Levels: 1-9. Time: 30-60 minutes.

Buswell-John Diagnostic Test for Fundamental Processes in Arithmetic. G. L. Buswell and Lenore John. Bobbs-Merrill. An individual test for children with problems in arithmetic. The pupil does the work aloud. Grade Levels: 1-6. Time: 20 minutes.

Keymath Diagnostic Arithmetic Test. A. Connolly, W. Machtman, and E. Pritchett. American Guidance Service, Inc., 1971. Twelve subtests in the areas of content, operations, and applications assess general information in all areas of math with minimum paper-and-pencil computations. Grade Levels: K-6. Time: 30 minutes.

SPELLING

Ayer Standardized Spelling Test. Fred C. Ayer. Steck-Vaughn Co., 1950. Grade Levels: 9-12. Time: 30 minutes.

Gates-Russell Spelling Diagnostic Test. A. I. Gates and D. H. Russell. Bureau of Publications Columbia University, 1937.

Lincoln Diagnostic Spelling Test. Public Schools Publishing Co., 1949, 1951. Grade Levels: 5-12. Time: 50 minutes.

HANDWRITING

Ayers Measuring Scale for Handwriting. Leonard P. Ayers. Cooperative Test Division, Educational Test Service. Grade Levels: 5-8.

Cursive Writing Evaluation Scale. Zaner Bloser. Grade Levels: 3-6

Manuscript Writing Evaluation Scale. Zaner Bloser. Grade Levels: 1-4

SELF HELP

San Francisco Vocational Competency Scale. Sam Levine and Freeman Elsey. Psychological Corp., 1968. Thirty items encompassing four dimensions of vocational competence: motor skills, cognition, responsibility and social-emotional behavior. Age Range: for retarded adults. Time: untimed.

Vineland Social Maturity Scale. Edgar A. Doll. American Guidance Service, Inc., 1965. This scale provides an outline of detailed self-help tasks listed in increasing difficulty. Age Range: birth-maturity. Time: 20-30 minutes.

APPENDIX F

BIBLIOGRAPHY OF INSTRUCTIONAL MATERIALS AND EQUIPMENT

BIBLIOGRAPHY OF INSTRUCTIONAL MATERIALS AND EQUIPMENT

MOTOR

Body Management Activities. MWZ Associates.

Daily Sensorimotor Training Activities. Educational Activities, Inc. Activities for gross motor, fine motor and perceptual motor. Ages: 4-7.

Eye-hand Coordination Exercises. Teaching Resources. Develops skills of discrimination and dexterity. Requires control of body posture, balance, and fluidity of movement.

Move, Grow, Learn Program. Follett Publishing Co. 160 exercises and procedures to develop movement skills, creativity, body awareness and other abilities. Grade: K-6.

Pathway School Program. Teaching Resources. Contains two wooden bats, wall plague, hollow plastic ball and a wooden paddle. Assists children in developing eye-hand coordination.

SENSORY/PERCEPTUAL

Auditory Discrimination in Depth. Teaching Resources. A multisensory program that develops the auditory-perceptual skills basic to reading, spelling, and speech. All ages.

Auditory Perception Training. Developmental Learning Materials. Tapes and spirit masters for: 1) auditory memory, 2) auditory motor, 3) auditory figure-ground, 4) auditory discrimination, 5) auditory imagery. Grades: K-6.

Cheves Program, Visual-Motor Perception Teaching Materials. Teaching Resources. There are eleven basic teaching materials. Each material is taught in isolation and then integrated to make them part of the total learning process.

Dubnoff School Program/2. Teaching Resources. Directional-spatial Pattern board with exercise cards to promote the development of directionality.

Erie Program/I - Perceptual Motor Exercise. Teaching Resources. This program is made up of three units: 1) Visual-perceptual exercises, 2) Perceptual Bingo, and 3) Visual-Motor Template Forms.

Fairbanks - Robinson Program. Teaching Resoures. There are eleven subsections, each dealing with a specific area of perceptual motor problems, including, line and form discrimination, spatial orientation, firgure-ground discrimination, spatial concepts and spatial relationships.

Fitzhugh Plus Program. Allied Education Council. Self teaching workbooks designed to provide help in spatial organization, language and numbers.

Frostig Program for the Development of Visual Perception. Follett Publishing Co. Spirit masters and three workbooks for developing visual perceptual skills.

Michigan Tracking Program. Ann Arbor Publishers. Symbol Tracking, Primary Tracking, Visual Tracking and Word Tracking are workbooks which aid in the remediation of visual discrimination, visual tracking, and sequencing skills.

Sounds I Can Hear. Scott, Foresman Co. Children identify sounds heard around school, home, farm and neighborhood. Grades: K-2.

The Remediation of Learning Disabilities: A Handbook of Psychoeducational Resource Programs. Robert E. Valett. Fearon Publishers. A handbook of activities for motor development, perceptual-motor skills, auditory and visual skills.

Visual Sequential Memory Exercises. Developmental Learning Materials. Helps transfer cognitive functions involved in perception and memorization to academic work. Grades: 1-3.

Visual Symbol Environment. Visual Symbol Environment. Designed for children 3 to 7 years old. Develop the coordinations of visual stimuli and meaning essential to reading achievement.

SPEECH AND LANGUAGE

A Sequentially Complied List of Instructional Materials for Remediational Use with the ITPA. Harold A. Rupert. Rocky Mountain Special Education Instructional Materials Center.

Building Language Usage Power. Miller-Brody Productions, Inc. Elements of simple sentences, action words, plural nouns, verb changes, recognizing main idea. Contains 5 records with manuals. Grades: 3-6.

Concepts for Communications. Developmental Learning Materials. The CFC program is divided into three units: 1) Listening with Understanding, 2) Concept Building, and 3) Communication.

Distar Language I and II. Science Research Associates. Highly structured program designed to teach basic language concepts and build vocabulary. Grades: pre-school - 2.

Emerging Language. The Learning Business. Sequential behavioral objectives for language acquisition from one word level to various informations. Materials not included. Ages: 2-10.

Game Oriented Activities for Learning (GOAL). Milton Bradley. 337 lesson plans and materials for ITPA-based activities. Grades: pre-school - 1.

Language of Directions (for Deaf). Alexander Graham Bell Association. Work-text for teaching the language of direction for language deprived children as well as the deaf.

Language Master. Bell and Howell. A recorder/player for use with cards on which a strip of 2-track tape is fixed. Onetrack is recorded on student mode and one on instructor mode. A large variety of pre-printed cards are available for instruction of language development, word recognition, and arithmetic.

Language Patterns. Milton Bradley. Identifying categories, establishing attributes, reviewing outcomes. 10 lessons on cassettes, 10 packs of 72 individual response sheets to record progress. Grades: 1-3.

Peabody Language Development Kits. American Guidance Service. Kits using a variety of materials are designed to stimulate oral language. Grades: K-4.

Picto-Vocabulary Series. Barnell-Loft. Involves comprehension of new vocabulary words. Grades: 5-8.

The MWM Program for Developing Language Abilities. Educational Performance Associates. A kit of remedial materials based on language disabilities as diagnosed by the ITPA. Ages: 3-11.

The Wilson Initial Syntax Program. Educators Publishing Service, Inc. Teaches basic syntatic patterns–prepositions, pronouns, plurals, verbs. Ages: 3-7.

ACADEMIC

READING

Action Reading System. Scholastic Book Services. Reading levels from 2.0-5.0 Kit of reading material for secondary school students who are seriously behind in reading.

Basic Set of Word Making Cards. Word Making Productions, Inc. The set contains 420 color pictures of common objects, people and animals. In each unit there are pictures using one particular sound in all three positions in a word. Grades: K-4.

Conquests in Reading. Webster Division, McGraw-Hill. A work-text in which phonics instruction is integrated with reading, writing, and spelling. Grades: 1-6.

Cracking the Code. Science Research Association. A student workbook designed to utilized phonetic and sight word methods to teach inductive reading and comprehensive skills. Grades: 2-6.

Cyclo-teacher Learning Aid. Field Educational Publications, Inc. Kit for practice in word attack skills, English, spelling, social studies and mathematics. Grades: 3-8.

Distar Reading Instructional System. Science Research Association. This system is based on learning by "seeing and saying." Complete teacher directions for group activities. Grades: K-2.

Edmark Reading Program. Edmark Associates. A programmed approach designed for students with extremely limited skills.

Handbook in Diagnostic Teaching. Phillip Mann and Patricia Suiter. Allyn and Bacon.

Individualized Reading Skills Improvement. Love Publishing Co. Emphasizes vocabulary, alphabetical order, dictionary use, and spelling. The workbook encourages a wide range of responses. Grades: 1-6.

Lift-Off to Reading. Science Research Associates. A programmed beginning reading approach.

Michigan Language Program. Ann Arbor Publishers. A highly programmed series in reading with a linguistic base. Grades: K-1.

Open Court Basic Readers. Open Court Publishing Co. A total language approach to reading. Grades: K-2.

Palo Alto Reading Program. Harcourt,Brace, Jovanovich. A linguistic reading series consisting of 20 paperbound pupils' books with corresponding workpads. Grades: K-3.

Peabody Rebus Program. American Guidance Service, Inc. This consists of three programmed workbooks which introduce the use of context clues, structural analysis, and phonetic skills. Grades: K-1.

Phonics Skilltext. Charles E. Merrill Books, Inc. The program provides meaningful content instead of isolated drill exercise and training in word recognition skills. Grades: 1-6.

Phonics We Use Learning Games. Lyons and Carnahan. A box with 10 games to teach consonant sounds, blends, vowel sounds, and other phonetic skills. Grades: 1-5.

Reading for Living Series. Laubach Literacy, Inc. A series of 9 booklets designed to develop the application of reading to life situations. Grades: 4-6.

Reading with Phonics. Lippencott. A controlled vocabulary reader with a phonetic emphasis. Grades: 1-3.

Readmaster. Ken-a-vision. An electric pacing device which may be used for pacing reading or tachistoscopic presentation of single stimuli in reading and math.

Specific Skills Series. Barnell Loft, Ltd. Designed to develop these skills: following directions, getting the main idea, using the context, and drawing conclusions. Grades: 1-6.

Sullivan Programmed Reading. McGraw-Hill Book Co. A linguistic reading program with a work-text whi is self-correcting and designed to be used independently by the student. Grades: 1-6.

Time for Phonics, Fun with Phonics. Webster Division, McGraw-Hill Co. Work-text series for teaching phonics. Grades: 1-6.

Webster Classroom Reading Clinic. Webster Division, McGraw-Hill Co. A comprehensive remedial reading program. Grades: 3-6.

MATH

Attriblocs. Mind/Matter Corp. 60 blocks of various shapes used to teach shape discrimination, tactile skills, set theory, operations, and logical thinking. Grades: K-12.

Arithmetic Step by Step, Kit A and B. Continental Press. Kit A contains sequential worksheets in counting, time, measurement and geometric shapes. Kit B contains worksheets dealing with basic operations, fractions, graphs, and decimals. Grades: 1-6.

Continuous Progress Math Laboratory. Educational Development Corp. An individualized program that is correlated to leading math textbooks. The kit contains a learning card and a cassette tape for each lesson.

Distar Arithmetic I and II. Science Research Associates, Inc. These kits represent a structured approach to the teaching of fundamental mathematics.

Individualized Arithmetic Instruction. Love Publishing Co. This workbook consists of different exercise sheets such as arithmetic squares, grouping numbers, open problems, and coded arithmetic. Grades: 1-6.

Learning About Number Kits. Gage Educational Publishing Limited. The kit includes concepts involving quantity, counting and seriation. Grades: K-3.

Lennes Essentials of Drill and Practice in Arithmetic. Laidlaw Brothers. A worktext which contains tests, instructional worksheets and oral practice of basic operations. Grades 1-8.

Math Lab. Benetic Press. A kit of boxed cards with activities to teach mathematical concepts. Grades: 1-8.

Mathematics for Employment. Mafex Associates. Deals with basic operations, using sales tax, and making change. Grades: 7-12.

Mathematics for Everyday Living. Mafex Associates. Covers sales tax, using a savings and checking account and working in a restaurant. Grades: 7-12.

Mathematics for the Worker. Mafex Associates. Contains units on restaurant and gas station work, and money management. Grades: 7-12.

Moving up in Numbers. Developmental Learning Materials. This is a kit of seven sequential units beginning with number sequence and proceeding through the operations of addition, two-digit multiplicands, and division. Grades: 1-6.

Number Tracking and Multiple Tracking. Ann Arbor Publishers. Both workbooks are independent and individual programs designed to aid visual training with numerals. Grades: 1-8.

Numero Cubes. Developmental Learning Materials. Ten dice, some with dots and some with numerals, which may be used in a variety of ways to teach basic operations in arithmetic.

Pacemaker Arithmetic Readiness Program. Fearon Publishers. Includes number sequence, reading and writing numbers, ordinal value, and basic shapes. Grades: preschool-3.

Primary Math Skills Improvement. Imperial International Learning Corp. This kit contains 40 tapes with approximately 4 worksheets per tape. Sheets are self-correcting. Grades: 1-6.

Rapid Easy Self-Teaching Chart. Cook and Company. These charts use a revolving disc tachistoscope to present number combinations in the four operations. Grades: 2-6.

Self-Teaching Arithmetic. Scholastic Book Services. Each of the five levels consists of hardback book with 32 lessons and a "magic" slate for recording answers. Grade: 1-6.

Structural Arithmetic. Houghton-Mifflin Co. This program is designed for use of concrete materials which allows the child to discover the basic concepts of numeration and arithmetic operations through following a carefully planned sequence of experiments. Grades: K-3.

The Sensorithmetic Program. Developmental Learning Materials. Teaching basic number and arithmetic concepts through the use of sensory reinforcement materials.

Unifix Materials. Educational Teaching Aids. Set of concrete materials to be used in teaching basic arithmetic concepts. Grades: K-6.

Working with Numbers. Steck-Vaughn Co. A sequential program in basic arithmetic and numeration concepts. Grades: 1-6.

SPELLING

Basic Goals in Spelling. Webster Division, McGraw-Hill. Grades: 2-8.

Dr. Spello. Webster Division, McGraw-Hill. Phonics and spelling book. Grades : 4-9.

Follett Spelling Program. Follett Publishing Co. Grades: 1-6.

Michigan Spelling Series. Ann Arbor Publishers.

Programmed Spelling. Ann Arbor Publishers. Programmed spelling workbook for junior and senior high school students.

Spellbound. Educator's Publishing Service. Text for poor spellers in junior and senior high school.

Sullivan's Programmed Spelling. Behavioral Research Laboratories. Individualized programmed workbooks for teaching spelling. Grades: 1-8.

HANDWRITING

Better Handwriting for You. Charles Merrill Co. Grades: 3-8.

Cursive Writing. Ann Arbor Publishers. Two books give programmed instruction in manuscript, cursive equivalents, letter shapes, letter locations and drawing letters. Grades: 3-6.

Guides for Writing. Instruction Corp. Two acetate sheets lined for handwriting practice on the 2-ruled guides for writing.

I Can Do It. The Zaner-Bloser Co. Designed to utilize visual, auditory, kinesthetic and tactile processes to develop writing skills. Grades: 1-5.

Learning About Handwriting. Frank E. Richards Publishing Co. Manuscript and cursive workbooks which teach handwriting by a tracing and copying method.

Let's Write. Hayes School Publishing Co. A practice writing series for spirit or liquid duplicator. Grades: 1-2 (Manuscript), 3-6 (Cursive).

New Basic Approach to Modern Handwriting. Numark Publications, Inc. A workbook format provides remediation in handwriting. Allows for independent work. Grades: 4-8.

Peterson Handwriting. Peterson Handwriting. Grades: 1-6.

Type It. Educators Publishing Service, Inc. A linguistically oriented typing manual. It is constructed to reinforce the reading and spelling patterns of the phonetically regular words in our language.

Write and See. Lyons and Carnahan, Inc. Programmed instruction in the formation of manuscript and cursive letters on lined paper.

SELF HELP

Developing Better Self Awareness Kit #102. Educational Innovations, Inc. Includes student workbooks, charts, puzzles and games. Grades : preschool - 3.

DUSO Kits. American Guidance Service. Developing Understanding of Self and Others (DUSO) is a program of activities, with an accompanying kit of materials, designed to help children understand social-emotional behavior. Grades: 1-3 (kit #1) 4-6 (kit #2).

APPENDIX G

BIBLIOGRAPHY OF BEHAVIORAL CHECKLISTS

BIBLIOGRAPHY OF BEHAVIORAL CHECKLISTS: INVENTORIES AND CHECK LISTS OF ADAPTIVE BEHAVIOR

AAMD Adaptive Behavior Scales (Revised)

American Association on Mental Deficiency

Balthazar Scales of Adaptive Behavior for Profoundly and Severely Retarded

Research Press Company

Basic Concept Inventory

Follett

Basic School Skills Inventory

Follett

Behavioral Outcome Charts

Colorado State College, Greeley, Colorado

Cain-Levine Social Competency Scale

Consulting Psychologists Press, Inc.

California Preschool Social Competency Scale

Consulting Psychologist Press, Inc.

Camelot Behavior Checklist

Edmark Associates Bellevue, Washington

Child Behavior Rating Scale

Western Psychological Services

Denver Developmental Screening Test

Ladoca Publishing Foundation, Inc.

Developmental Evaluation Checklist

Pediatric Services Roosevelt Hospital

Developmental Task Analysis

Follett

Devereau Behavior Rating Scale

Devereau Foundation

Diagnostic Checklists (Developmental Skills) I, II, and III

Utah State Division of Health, Handicapped Children's Service

Evaluation Form for Trainable Mentally Retarded Children

Rocky Mountain Special Education Instructional Materials Center

Gesell Developmental Scale

Gesell Developmental Kit, Lumberville, PA

Individual Student Inventory

Tri-County Special Education District; Murphysboro, Illinois

Inferred Self Concept Scales

WPS

Inventory of Developmental Behaviors

Fox Developmental Center; Kankakee, Illinois

Louisiana Adaptive Behavior Scale

Division of Mental Retardation, Louisiana Health and Social Rehabilitation Services

Nebraska Client Progress System

Nebraska Department of Public Institutions

Ottawa School Behavior Checklist

Psychological Consultants, Inc.

Pupil Rating Scale - Screening for Learning Disabilities

Grune and Stratton

Riley Preschool Developmental Screening Inventory

Western Psychological Services

Santa Clara Inventory of Developmental Tasks

R. L. Zweig Associates

Title I Needs Assessment - Severely and Profoundly Retarded

Minnesota Department of Education; St. Paul, Minnesota

TMR Performance Profile

Reporting Service for Exceptional Children; Ridgefield, New Jersey

Vineland Social Maturity Scale

American Guidance Service, Inc.

Walker Problem Behavior Identification Checklist

WPS

APPENDIX H.

ON WRITING BEHAVIORAL OBJECTIVES

ON WRITING BEHAVIORAL OBJECTIVES

Lanny Morreau, Ph.D.
Illinois State University

1. The systematic design of instruction has been prolifically described in the literature, and much of the associated "jargon" has become common language in the field of education. Unfortunately, in spite of the popularity of the topic, systems approaches are more often discussed as being theoretically applicable to instruction than applied to the improvement of instructional practices.

A systems approach is a process by which instructional planning can be completed to meet the specific needs of individual learners. The process also provides a procedure by which teachers can evaluate their instruction in terms of individual learner progress as contrasted to overall "class" performance.

2. Behavioral Objectives

The primary index of the effectiveness of our instruction is the change in the behavior of the learner. We are committed to assisting students in acquiring new behaviors and in increasing or decreasing the occurrence of existing behaviors. The fact that we arrange experiences presumes that we have, either independently or with the learner, determined which behaviors should be increased and which behaviors should be decreased. These decisions need not occur randomly; they should occur by design.

We should specify the precise behavior the learner will acquire, the stimulus conditions

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Adapted from (1) Morreau, L. E. Behavioral Objectives: Analysis and Application. In H. Maloney (Ed.) Accountability and the Teaching of English. National Council of Teachers of English, Urbana, 1972 and (2) A paper under the present title published in the Proceeding of the Minnesota Special Studies Institute on Education of the Deaf. University of Minnesota, 1975.

under which the behavior will occur, and the precise criterion which will indicate when the learner has been successful - we should state the objectives of our instruction in behavioral terms. Each of these objectives should then be subdivided into specific steps which the learner must master in order to meet the objectives.

3. Conceptual Objectives

The conceptual objectives describe the generalized goal or outcome of the total program. They should describe the general skills the "ideal" learner would demonstrate after the formal educational experience was completed. These objectives serve as a guide for the development of more specific objectives. From an instructional standpoint, they mean very little; from a developmental standpoint, they are essential.

Example: The learner will be able to apply the skills necessary for obtaining and maintaining a vocational position.

4. Educational Objectives

Each conceptual objective must be reduced to the specific skill areas in which a learner must demonstrate competence for the conceptual objective to be met. The emphasis is placed on including all of the skill areas.

Example: The learner will understand the procedures for acquiring a job.

5. Instructional Objectives

The educational objectives are represented by a variety of behavioral classes, e.g., identity, name, describe, demonstrate. Each educational objective must be reduced to classes of behavior with specific subject-area descriptors.

Example: The learner will demonstrate the basis techniques of a job interview.

6. Behavioral Objectives

A number of behavioral objectives would be written to represent the class of behavior in each instructional objective. The behavioral objectives are comprised of four major components: The indivudual learner, the conditions, the measurable verb (or action), and the criterion measures for the action.

Example: When asked five personal history questions in a hypothetical peer-directed job interview, the learner will answer each question accurately without reference to his notes.

Because of its precision the behavioral objective serves as a guide for the development and evaluation of instructional prodedures.

7. The Condition

The learner might be faced with disaster if all his activities were directed toward a written response to printed material and we measured his progress with an oral check. The conditions indicate the procedures to be used in evaluation and guide us in selecting educational experiences. If mastery of a given skill is to be demonstrated by oral responding, it should be stated in the objective and the activities should be selected which increase the learner's skill in that area. Conditions can vary in terms of the amount of support the learner will receive, e.g., with teacher assistance, independently; the type of prompts the learner will use, e.g., given an alphabet card, with no cues; and the situation where the learner will demonstrate mastery, e.g., in the classroom situation, in a "real-life" situation.

8. The Action

Behavioral objectives specify what the learner can do, not what he "knows." Because the action is observable and measurable, we can precisely evaluate the effects of materials or activities in assisting the student to master the objective. The student's measured performance also serves as a guide for advancing him on the sequence of objectives.

9. The Criterion Measure

Stating the precise quantity or quality of responses which indicate mastery of a given skill assures that each learner is advanced to more complex objectives only after he has the skills necessary for mastering them. We are also able to report the learner's progress more precisely; he doesn't just "know more," he can "do" a specific task at a specific level of accuracy.

10. The Objective Base

By proceeding through an objectives development sequence as depicted in Figure 1, we insure that the objectives for our students will be meaningful - directly related to their ability to perform after they have left the formal program.

The resulting behavioral objectives, in turn, provide numerous advantages for both learners and teachers;

The teacher can effectively communicate with the learner, his parents and colleagues about the program.

The teacher can reinforce the learner for specific progress toward the objective.

The teacher can precisely measure progress.

The teacher can locate the point in the sequence at which the learner is prepared to begin.

The teacher can report progress in precise terms.

The teacher can select materials and activities to meet the needs of the individual learner.

The learner knows where he is going.

The learner may more easily see the relevance of specific tasks.

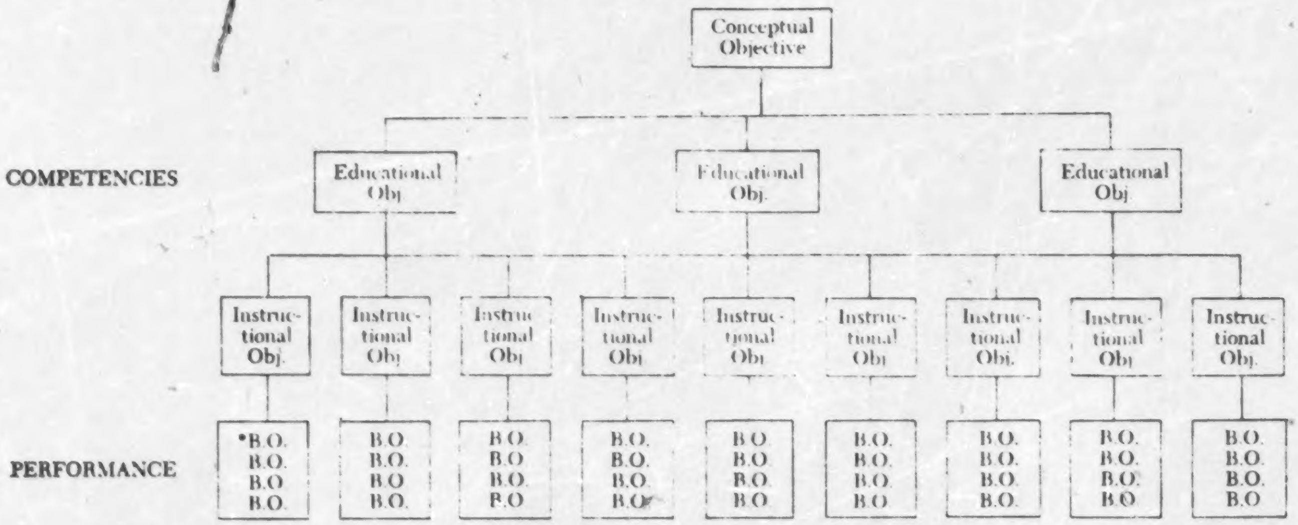
The learner can be involved in education decision-making.

The learner knows what is expected of him.

The learner can measure his own progress.

Figure 1

Guidelines for Writing and Sequencing Objectives


Conceptual Objective
COMPETENCIES
Educational Obj.
Educational Obj.
Educational Obj.
Instructional Obj.
Instructional Obj.
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PERFORMANCE
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* Behavioral Objective

References

Jenkins, J. R., & Deno, S. L. A model for instructional objectives: Responsibilities and advantages. *Educational Technology,* November, 1970, 11-16.

Morreau, L. E. *The behaviorally engineered classroom: A learner sensitive environment.* Minneapolis: Upper Midwest Regional Educational Laboratory, 1971.

Morreau, L. E. Behavioral Objectives: Analysis and application. In Maloney, H. (Ed.) *Accountability and the teaching of English.* Urbana, Illinois: National Council of Teachers of English, 1972.

Morreau, L. E. The structural analysis and classification of objectives. *Educational Technology,* March, 1974,46-48.

Morreau, L. E. *Task Analysis.* In Press, 1975.

APPENDIX I.

LIST OF PUBLISHERS

List of Publishers

Allied Education Council
P. O. Box 78
Galien, Mich. 49113

Allyn & Bacon
470 Atlantic Ave.
Boston, Mass. 02210

American Guidance Service, Inc.
Publishers Building
Circle Pinces, Minn. 55014

Ann Arbor Publishers
P. O. Box 338
Worthington, Ohio 43085

Barnell-Loft
958 Church Street
Baldwin, NY 11510

Behavioral Research Laboratories
P. O. Box 577
Palo Alton, Calif. 94302

Bell and Howell
7100 McCormick Rd.
Chicago, IL 60645

Benefic Press
10300 W. Roosevelt Rd.
Westchester, IL 60153

The Bobbs-Merrill Co.
4300 W. 62 St.
Indianapolis, Ind. 46206

California Test Bureau
A Division of McGraw-Hill
Del Monte Research Park
Monterey, Calif. 93940

Continental Press, Inc.
Elizabeth, Pa. 17022

Council for Exceptional Children
1920 Association Drive
Reston, VA 32091

Developmental Learning Materials
7440 N. Natchez Ave.
Niles, IL 60648

Devereau Foundation
Devon, PA

Edmark Association
655 S. Orcas St.
Seattle, Washington 98108

Educational Activities, Inc.
1937 Grand Ave.
Baldwin, NY 11520

Educational Developmental Laboratories
A Division of McGraw-Hill
1121 Avenue of the Americas
New York, NY 10020

Educator's Publishing Service
75 Moulton St.
Cambridge, Mass. 02138

Educational Testing Service
Princeton, NJ 08540

Essay Press
Box 5
Planetarium Station
New York, NY 10024

Fearon Publishers
6 Davis Drive
Belmont, Calif. 94002

Follett Publishing Co.
1010 Washington Blvd.
Chicago, IL 60607

Garrard Publishing Co.
1607 N. Market
Champaign, IL 61820

Harcourt,Brace, Jovanovich, Inc.
757 Third Ave.
New York, NY 10017

Houghton Mifflin Co.
One Beacon St.
Boston, Mass. 02107

Houston Press
University of Houston
Houston, Texas 77000

Keystone View Co.
2212 E. 12 St.
Davenport, Iowa 52803

Lyons and Carnahan Educational Publishers
407 E. 25 St.
Chicago, IL 60616

Mafex Associates, Inc.
111 Barron Ave.
Johnston, PA 16906

McGraw-Hill Book Co.
1221 Avenue of the Americas
New York, NY 10020

Charles E. Merrill
1300 Alum Creek Dr.
Columbus, Ohio 43216

Open Court Publishing Co.
Box 599
1039 Eighth St.
LaSalle, IL 61301

Phonovisual Products
12216 Parklawn Dr.
Rockville, Md. 20852

The Psychological Corp.
304 E. 45 St.
New York, NY 10017

Scholastic Magazine and Book Services
50 W. 44 St.
New York, NY 10036

Science Research Associates
259 E. Eric St.
Chicago, IL 60611

Scott, Foresman And Co.
1900 E. Lake Ave.
Glenview, IL 60025

Slosson Educational Publications
140 Pine St.
East Aurora, NY 14052

Steck-Vaughn Co.
Box 2028
Austin, Texas 78767

C. H. Stoelting Co.
424 N. Homan Ave.
Chicago, IL 60624

Teaching Resources Corp.
100 Boylston St.
Boston, Mass. 02116

University of Illinois Press
Urbana, IL 61801

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, Calif. 90025

Aner-Bloser Co.
612 N. Park St.
Columbus, Ohio 43215

Educational Teaching Aids
159 W. Kinzie St.
Chicago, IL 60610

Mind/Matter Corporation
P. O. Box 345
Danbury, Conn. 06801

Hayes School Publishing Co.
R. R. #2
Mt. Vernon, IL 62864

Instructo Corporation
Paoli, Penn. 19901

Numark Educational Systems
Forest Hills, NY 11375

Frank E. Richards Publishing Co.
324 First St.
Liverpool, NY 13088

Peterson Handwriting Co.
P. O. Box 249
Greensberg, PA 15602

Educational Innovations, Inc.
203 N. 4th St.
Carralltown, IL 62016

Special Child Publications
4535 Union Bay Pl., N.E.
Seattle, Wash. 98105

Bureau of Publications
Teaching College Press
Columbia University
525 W. 120th St.
New York, NY 10027

Grune and Stratton, Inc.
111 Fifth Ave.
New York, NY 10003

Research Press Company
CFS Box 3327
Champaign, IL 61820

Consulting Psychologist Press, Inc.
577 College Ave.
Palo Alto, Calif. 94306

Ladoca Publishing Foundation, Inc.
E. 51st Avenue of Lincoln St.
Denver, Colo. 80216

R. L. Zweig Associates, Inc.
20800 Beach Blvd.
Huntington Beach, Calif. 92648

MWZ Associates
P. O. Box 144
Dayton View
Dayton, Ohio 45406

Visual Symbol Environment
64 East Second St.
Winona, Minn. 55987

Alexander Graham Bell Association for the Deaf, Inc.
1537 35th St., N.W.
Washington, D. C. 20007

Miller-Brody Production, Inc.
342 Madison Ave.
New York, NY 10017

Gage Educational Publishing, Limited
P. O. Box 5000
Agincourt, Ontario Canada MIS 3C7

The Learning Business
30961 Agoura Rd., Suite 325
Westlake Village, Calif. 91361

Milton Bradley
74 Park St.
Springfield, Mass. 01106

Childcraft Educational Corp.
150 E. 58th St.
New York, NY 10022

Educational Performance Associates
563 Westview Ave.
Ridgefield, NJ 07657

Love Publishing Co.
6635 E. Villanova Pl.
Denver, Colo. 80222

Word Making Production, Inc.
P. O. Box 1858
Salt Lake City, Utah 84110

L. B. Lippencott Co.
E. Washington Square
Philadelphia, PA 19105

Field Educational Publications
902 S. Westwood
Addison, IL 60101

Ken-a-Vision
5615 Raytown Rd.
Kansas City, Missouri 64133

Laidlaw Brothers
Thatcher and Madison Sts.
River Forest, IL 60305

Imperial International Learning Corp.
P. O. Box 548
Kankakee, IL 60901

David C. Cook Publishing Co.
850 Grove Ave.
Elgin, IL 60120